

JUN 27 1949

# The Psychiatric Quarterly

OFFICIAL SCIENTIFIC ORGAN OF THE NEW YORK STATE  
DEPARTMENT OF MENTAL HYGIENE

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Published at the State Hospitals Press  
Utica State Hospital, Utica, N. Y.



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PUBLISHED BY AUTHORITY OF THE  
NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

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The Psychiatric Quarterly, formerly the State Hospital Quarterly, is the official organ of the New York State Department of Mental Hygiene.

Volumes begin with the January number. Individual subscription rate, \$4.00 a year in U. S. and its possessions; \$4.50 elsewhere.

Editorial communications, books for review and exchange should be addressed to the editor, Dr. Newton Bigelow, Utica State Hospital, Utica, N. Y.

Business communications, remittances and subscriptions should be addressed to the State Hospitals Press, Utica, N. Y.

Entered as second-class matter April 17, 1917, at the postoffice at Utica, N. Y., under the Act of March 3, 1897.

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## LYING: A MINOR INQUIRY INTO THE ETHICS OF NEUROTIC AND PSYCHOPATHIC BEHAVIOR

BY BEN KARPMAN, M. D.

### I

The quest for the true, the good, and the beautiful has from time immemorial provided the strongest incentives in the life of mankind. Different cultures, different epochs have placed varied emphases on these—emphases which explain different standards, as for instance, Greek culture, which stressed aesthetics, and the Oriental culture, which regards honor as more important than honesty. Our own modern culture emphasizes more strongly good vs. evil, than knowledge vs. ignorance, or the beautiful vs. the ugly. The good is our cultural imperative and is the backbone of our socio-economic, political and legal systems. The sole legal test of sanity vs. insanity is today not in terms of superior or inferior intelligence, but in terms of knowing the difference between right and wrong, essentially a contrast in values.

Quite universally, all religions, be they monotheistic like the Judaeo-Christian systems, the Buddhist-Shinto system, the polytheistic religions, and many others, are oriented in one direction, that of goodness. The Bible speaks with condemnation of wicked lips and lying tongues. Guilt would not have played such a tremendous role in our life but for the fact that man, the perfectionist, falls short of the ideal of goodness and virtue that has been set for him. Throughout, honesty, goodness and virtue are presented to us as the *summum bonum humanitatis*, as well as the best means for survival; while lying, in its many varieties and types, is represented as most reprehensible, and the core of all human vices. In philosophy, ethics occupies a more important position than either epistemology or aesthetics. Whether man is inherently good (Bishop Berkeley) or acquires the knowledge of goodness through experience (Locke), is still a favorite topic for discussion at philosophical tables. Social movements base their incentives on social values and virtues, however they may clothe them with knowledge and reason.

How thoroughly the idea of ethics has permeated our life is seen in the fact that quite universally criminals try to find justifications, however gossamer, for their behavior, which they recognize as anti-social, though it is true that their attitude toward truth is

only too often verbal and that they pay only lip service to guilt. And what, after all, is a lie but an attempt on the part of an individual to appear in a more favorable light to make him seem more honest or better than he actually is, thus again making basic honesty and goodness the chief criterion in his life?

## II

Withal, lying permeates our daily life, personal and social, however it may be disguised by the thin veneer of social convention. How many people are honest with themselves, let alone with others? The use of cosmetic articles by woman, regarded but a few centuries ago as a crime, because employed for the purpose of deceiving man, is now an accepted mode of behavior; a woman feels that she is exhibitionistic if she does not use rouge or lipstick whereas, in point of fact, the case is the very opposite. We all try to put the best foot forward, win friends and influence people, and are not too careful about the means employed. One shudders to think what sort of life ours would be if every one of us were completely and entirely truthful. In our daily pastimes, such as card games, we attempt to deceive our partners into wrong playing by "poker" faces or otherwise making misleading moves. Can one picture what sort of interpersonal relationship would be established if Mrs. Jones told Mrs. Brown just exactly what she thought of her, and Mrs. Brown returned the compliment? How many automobiles could a salesman sell if he told the prospective buyer all the mechanical faults of his automobile while at the same time admitting the undoubted superiorities of his competitors' products? How many lawyers in defending a particular client are willing to tell the judge and jury the unvarnished truth as they actually know it, or fail to exaggerate the favorable aspects of the case, appealing for the most part to the emotions of the jury rather than to reason? How many district attorneys, set to win a case and secure a conviction, do not equally go the limit to create prejudices in the minds of the jury? Our huge advertising system is based on deceptions and gross misrepresentations, as is also propaganda of various sorts, not excepting that of the powerful pressure groups and lobbies where all efforts are insincere attempts to cover up selfish interests. What would be his chances for reelection if every political aspirant were to tell his constituents, openly and frankly, his undoubted limitations, moral and ethical?

When the late President Harding was being nominated for the presidency by the Republican Party and was asked the usual question, "Do you know of anything that would disqualify you for the office?" his answer was in the negative. Yet his life history shows him to have carried on a clandestine affair, the discovery of which later so shocked the moral sensibilities of the American people that had it been known at the time, it would have certainly kept him from the presidential office.

Grafting and bribery are an almost acceptable part of our municipal, state and other governments, and go on daily under our very noses to the passive acquiescence of the citizenry, which now and then is shocked out of its complacency by such public scandals as the Fall-Teapot Dome, the Garsson Brothers-May munitions exposure, and the like. On such occasions, a great and spectacular trial is held, punitive sentences are meted out; the public conscience is appeased; but the matter soon quiets down; and the merry business goes on again. It is almost an accepted tradition in our political life that there is no sense in running for office unless one takes advantage of the opportunity to make a little extra money on the side. The late Boss Murphy, little appreciating the low character of ethics among the politicians he knew, neatly divided illicit income into honest graft and dirty money.

In his *The Conventional Lies of Civilization*, Max Nordau told us of some of the wholesale lying and cheating that goes on in our social life; there is enough material accumulated by this time to enlarge the scope of his volume to many times its size and still leave much untold. International relations, from diplomacy down (and up) are filled with misrepresentations, evasions, and deceptions of the grossest kind. The League of Nations fell apart, not because of external difficulties, but because of internal contradictions, because each member came with his own bag of tricks and pack of lies, each nation filled with its own hostilities and impossible-aggressive ambitions and a total unwillingness to understand anyone else. The spectacle is being repeated to date with the United Nations. How else can it be when Soviet Russia is grabbing everything within her sight, by means mainly foul rather than fair—at the same time disclaiming any responsibility for her overt Communistic activities and instead pleading that she is constantly being discriminated against by others? What are we to think of Britain, who voted with others for the partition of Palestine, yet

in the same breath engaged in manipulations behind the scenes, and armed the Arabs against the Jews? Perfidy is too mild a name for this. What shall one say of history, of which it has been stated that it is but a pack of lies agreed upon? Within the memory of many of us is the character of propaganda that goes on during a war; and some years later come the revealing books, *Now It Can Be Told*, the memoirs of such-and-such a statesman, etc. Propaganda not merely deceives; but whips and drives people into action desired by power and pressure groups.

Besides obvious forms of lying, there are many vicarious forms expressed in deceptions, cheating, mental reservations, simulations, frauds and falsehoods of all sorts, moderately tolerated by our society, until one passes to the grosser forms that are legally criminal, but qualitatively indistinguishable from civil lying that commonly obtains in interpersonal relations.\* Truly, it is no paradox that the greatest expression of honesty obtains among the "insane."

### III

Paradoxically enough, too, our mode of living not only allows for, but actually creates, many situations which make lying absolutely necessary if people are to get along socially. The cultural imperative is to repress the basically true and to express the socially desirable even if untrue. Our primitive urges, if uncontrolled and uninhibited, would not have allowed the formation of a social order which would be self-sustaining. Our primitive impulses, unless socially conditioned, would not have allowed us to get in contact with our fellow-men. Our loves, if unconstrained, would interfere with the love trends of other people. Our basic hostility, if uncontrolled or unmodified, would not have allowed the survival of our opponents. Society has required that man give up some of his primitive impulses if he is to derive any benefit from social intercourse. Our whole system of ethics and morals is built on that basis; and, precisely because of that, we have to resort to a great deal of lying.

\*The number of synonyms for "truth" is small, but those relating to lying may well fill several pages in the dictionary. To wit: affectation, bluff, buffoonery, cant, casuistry, canard, cheating, concealing, conniving, counterfeiting, deception, dishonesty, dissimulation, distortion, distrust, double cross, double face, double dealing, exaggeration, fake, fallacy, fabrication, falsehood, feigning, fraud, humbug, hypocrisy, impersonation, malingering, misrepresentation, perfidy, pretension, simulation, sophistry, trickery, understatement, untruthfulness, etc., etc.

Politeness, no doubt, is a form of hypocrisy. What we would like to tell the people we come in contact with, and what we actually tell them, are two entirely different things. By the time our original expression emerges to the surface, it has already been modified by our censorship. Social ethics require lying. We do not tell a man his faults, even if we are painfully aware of them, but we suppress our criticism and offer something that is benign. There is also good reason for this in the fact that unless we act that way toward our neighbors, they may equally well not act that way toward us. Therefore, "Love thy neighbor as thyself" may be not only a noble principle to follow, but a healthy and practical one as well, for if we can manage to approximate our love of our neighbor to that of ourselves, we have a right to hope that he will do the same thing toward us, thus giving us a better sense of security.

Pinocchio, it is related, would frequently tell lies. Every time he told a lie his nose would grow bigger until it got so big it began to curl upon itself and develop many branches. There was but one way in which to get his nose back into normal shape, and that was to stop lying, which he did—and happy he was indeed. But, having done away with lying, he began to play hookey from school—whereupon his ears began to grow longer. That was very uncomfortable, and annoying as well, for it gave conspicuous evidence of his bad behavior. There was but one thing to do, to stop lying, playing hookey or tricks and then, and then only, would he appear normal; the moral being that in order to appear normal in the eyes of society, one must keep away from lying and tricks.

At worst, or at best, lying comes out modified in the form of mild insinuations which are a considerable compromise with the original. Our humor and wit are sadistically colored.

Lying as such did not, of course, come into play until man learned to express himself verbally. It need not be supposed, however, that man began to lie that split second (or is it split millenium?) when he turned from quadruped into biped. Lying as a form of human expression has a long and colorful history. Giorgiade<sup>1</sup> develops the theme that "the lie, while of biological origin, has taken on the characteristics of magic when it passed through the mind of prehistoric man. Prehistoric man evolved from the stage of visual and spatial images to that of mimical and vocal expression; later he developed the capacity of abstraction from im-

mediate reality and, through the medium of language, to interiorize thought (imperceptible vocalization), thus guarding self-interest actions from his fellow-man. After acquiring language, the magical power of images was substituted by verbal magic. For primitive man the reproducing of objects through laryngo-oral images was equivalent to manipulation of real objects. Verbal magic resulted from this illusion. This in turn led to lying in order to escape from difficulties."

One might add here that lying goes back beyond prehistoric man. Deception or deceptive acting (mute lying) is not unknown in the animal world as in the well-known instance of death-feigning in the opossum, protective coloration in birds, etc.

#### IV

In his essay, *The Decay of Lying*, Oscar Wilde, the supreme aesthete of all time, argued eloquently and brilliantly for the beautiful against the true and spoke of lying as an art, an expression of superior imaginative power. "A story," he says, "if too true is robbed of its reality and is thus entirely inartistic. We must emphasize the poetical side, imagination and unattainable ideals." In substance, his thesis is that the essence of lying is exaggeration, a gift which if properly nurtured might grow into something really great. It is opposed to accuracy, which is fatal to imagination. We must cultivate the wit to exaggerate and the genius for romance. Modern fiction, Wilde believes, is commonplace because it is so close to reality. The cultured and fascinating liar should be the leader of our society. The true founder of social intercourse is the primitive man who invented fantastic tales of victories that never took place. The aim of the liar is simply to charm, to delight, to give pleasure. Lying for the sake of the improvement of the young is the basis of home education. "The only form of lying," continues Wilde, "that is absolutely beyond reproach is lying for its own sake and its highest development is lying in art. Those who do not love beauty more than truth never know the inmost shrine of art. In the lost art of lying, birds sing of beautiful and impossible things, of things that are lovely and that never happened, of things that are not and that should not be. The proper aim of art is lying, the telling of beautiful untrue things. Art is not necessarily realistic nor spiritual. All bad art comes from returning to Life and Nature and elevating them into ideals.

Art must not surrender its imaginative medium. Art is independent of time. Any century is a suitable subject for art except our own. The only beautiful things are the things that do not concern us."

We shall not argue with a genius whose writings are so beautiful, even if not true. It is clear, however, that Wilde views lying in the exceptional rather than the accepted meaning of the term. In daily, normal life we are acquainted with many and different forms of lying but we may distinguish chiefly two. First is the harmless, innocent lying (the white lie) which is regarded as benign because it satisfies some personal need in the individual without doing anyone any injury. It may even do another person good. Universally, it is a defense against real or fancied inferiority. It is not encouraged socially, because it is feared that the too-frequent use of it may lead to the more malignant form. The second form is the malignant type of lying, the purpose of which is the deriving of some personal benefit at the expense of someone else. This may range from relatively harmless and minor forms to the extreme one where one's life may be threatened. Such lying is not condoned for it threatens our security.

## V

Mankind has been kinder to its liars and falsifiers than it has been to its thinkers and truth-seekers. In the well-known saying "truth forever on the scaffold, wrong forever on the throne," one gets an explicit expression of the situation. Witness the glorification that we have accorded to dictators, to the Borgias and Richelieus, the Hitlers and Mussolinis, and contrast this with the attitude toward Socrates, Christ, the martyr-saints, John Huss and Savonarola, John Brown and Gandhi, all lovers of mankind, rare souls who were willing to make the ultimate sacrifice for the courage of their convictions. Blood had to be shed by rebellious minorities rising against the tyranny of foreign power to secure what was morally due them; the slaves who rose in arms against their masters, the abolitionists who, years in advance, saw the need of absolute freedom as a condition of progress and had to make so many sacrifices to secure what was their inalienable right against entrenched wrong.

And yet one is tempted to make a plea for, and a defense of, the liar. Often enough he is no more responsible for his lying than a

neurotic in general is responsible for his symptoms, for lying has all the earmarks of a neurotic symptom, and, like all neurotic symptoms, it does not appear and maintain itself in isolation but is intimately tied up with many other symptoms. Through an unwitting concatenation of circumstances, in the making of which he had no hand, the liar often finds himself in situations which immediately threaten his security and from which he finds himself unable to escape except by lying; it is as if the environment in which he functions demands lying on his part as a condition of survival. Inevitably, of course, one lie leads to another and still other lies, and these in turn, lead to deceptions, falsifications and cheating of all sorts. Why another person in a like situation would not resort to lying but would instead insist on telling the whole truth depends entirely upon the background, the nature of his repressions and the strength of his super-ego. The famous Samuel Johnson, when asked what he considered the greatest virtue, answered: "Courage, for if one has courage he can practice all other virtues." Physical courage (bravery) is the ability to go on in face of danger and at the risk of one's life and limb. The loss of life in wartime, tragic as it may otherwise be, carries with it the compensation of having sacrificed one's self for a country, and the possibility of immortality, and this provides a strong stimulus for action. Greater yet, however, is moral courage, for it requires the ability and willingness to sacrifice much of what one has against the tide of popular opposition; with the possibility of much loss and little gain. Most people, however, would rather lie out of a situation than courageously face it.

## VI

There are chiefly two professions, law and medicine, with perhaps the clerical between them, that are directly concerned with the problem of lying. Law deals primarily with the relationship between the individual and the community, always with predominant, if not exclusive, regard for the interests of the community and but little for the needs of the individual. By long, hard and, one might say, painful experience, society has learned what is the best it can do to promote the growth and maintain the welfare of the community, and it has crystallized these experiences into law. Law, therefore, depends a great deal on traditions and established precedents which through generations have become so rigid and

so structuralized as to have lost the emotional significance which they undoubtedly had originally; for, cold and objective as laws appear to us, they were at the time of their origin intensely personal, and represented emotional problems which the group had to solve if it was not to suffer damage from its individual members. The original attitude of man toward other human beings is not entirely one of positive social sentiments; there is a great deal in him of the isolate, who wishes nothing better than to escape contact with others. Sexual needs and perhaps his basic feeling of insecurity drive him to seek the co-operation of other human beings, and this fact is responsible for what has come to be known as social sentiment. To obtain such co-operation, he must perforce curb his aggression and sacrifice some of his personal desires. This he does not do readily or willingly, and the community is obliged constantly to put restraints on its members if it is not to suffer from their aggression. Through the medium of family training, and later through the influence of the school, the church and the community, the growing child develops a conscience and a sense of guilt, a ready obedience to dictates of culture (duty), and a willingness to sacrifice his personal needs for the larger interests of the community. While this training succeeds in most cases, its failure in others produces the anti-social and criminal elements of society.

It is at this point that lying comes in as a problem in law. In order that law may justly and properly evaluate the share of responsibility of the individual in the instance of an offense; in order that it may be sure that society will be protected and not suffer damage—and it quite universally gives society the larger benefit of the doubt—the law must have all the facts of the case, plain, unvarnished, unequivocal. It cannot afford, therefore, to admit lies. So concerned is society about lying that, not trusting the honesty and integrity of the defendant and the witnesses, it makes them take an oath, which is binding, and the violation of which, being perjury, becomes a legal offense.

In contrast, medicine as a profession, and its practice by the physician, is built entirely around the individual patient. To relieve pain, to alleviate suffering, to offer surcease from distress and sorrow, to provide the greatest comfort possible—this is the essential work of the physician. The ethics of the profession therefore demand that the welfare of the patient be its foremost

and greatest consideration; indeed, the only consideration. Accordingly, the physician will not regard truth as an absolute goal and lying as an evil *per se*, but will consider them only to the extent that they affect the individual patient. He will give the neurotic patient a placebo, knowing full well that it is a gross deception, but justifying himself by the consideration that: (a) it will give the patient a much needed rest and sleep—which is most important; (b) that if an opiate, barbiturate or other sleeping medicine were given, it might well lead, in susceptible individuals, to addiction—a medical evil. If a patient has an incurable disease, and if he is of the stoical type that can “take it,” it may be well enough to tell him the truth so that he can prepare himself accordingly. But most people are not stoical, and the knowledge of the truth, by adding an emotional burden to the already existing physical one, may only hasten the end of life. Is it worth while, then, to sacrifice a patient for the sake of an abstract truth? The physician is dedicated to prolonging life. In the physician-patient relationship he will lie to the patient, assuring him that there is still hope, and thus provide a moral force that can prolong life, even if only for a few hours. He will feed him with large doses of narcotics if this will relieve agony and prolong life; and, even as he is dying, he will put small pieces of ice between his lips to relieve the distress of the last hours.

Thus in a large sense the viewpoints of the professions of law and medicine are indeed opposite. The view of the law is social and communal; its interest in the individual member of society is secondary and remote. Built on hard and established precedents, law finds it difficult to break traditions and pave new ways. Law is conservative, not in a derogatory sense, but certainly in the sense that it wishes to preserve what has long been established and found socially useful. Medicine, on the other hand, is entirely individualistic. It is not directly concerned with social needs, even when it works socially, as in the field of public health. Even when it looks upon society as a sick body, the attitude and the approach are essentially individualistic.

Situations, however, may arise where the interests of the individual may well conflict with those of the law. John A. is a citizen known for his supreme honesty and high integrity. He is asked to testify on some matter and is sworn to tell all the truth he knows. He finds, however, that if he were to do that, he would

have to betray the earlier confidence of his friend, William B., which his conscience will not permit him to do. A conflict arises here between individual and social ethics, not always satisfactorily solved. A like situation may arise if a physician or a priest is asked to divulge the confidence given him professionally, and implicitly understood as given to remain confidential. If the physician or the priest be importuned to yield the information, many will consider it a betrayal of faith and trust; and, in the end, the whole thing may boomerang, if people, having lost faith, cease giving professional men confidential information.

Opposite though the viewpoints of the two professions may be, are they entirely irreconcilable? Can the twain ever meet on common ground? That, though not immediately feasible, would seem to be not impossible. To what extent medicine can afford to sacrifice its personal contact with the individual patient, is difficult to say. But this much is probably clear, that law will have to take greater cognizance of the criminal as an individual, perhaps think of the criminal as a patient to be treated rather than punished. The physician feels that society has produced the criminal, who neither chose his parents nor the environment in which he was brought up.

Another question related to lying which is viewed differently by the respective professions of law and medicine, is the problem of guilt. The law recognizes personal guilt and, in case of such guilt, expects the individual to acknowledge it unequivocally. The law further assumes that man is a free and responsible agent and that, being thus free and responsible, punishment will act as a sure deterrent from crime. The law, not being concerned with motives, is, therefore, not interested in what may have been the motive behind an individual's deed, which motive, if known, might help us to understand the nature of the guilt in relation to it. It is here that we observe a basic difference in the attitudes of the two professions. Medicine, in treating an illness, does not treat the symptoms, but the causes behind them; for it has long recognized that, however alike symptoms may be on the surface, they may well have widely different causations. To the psychiatrist, the behavior and the reaction are what symptoms are to the general medical man. He goes behind the particular deed, and wishes to ascertain the motive for it, for he realizes that a reaction itself is not

important unless it be judged in the light of the underlying motivations; that the same reaction and the same behavior may have different motivations in different individuals, and therefore must be judged accordingly. In the study of this motivation, he may discover that an individual has had particular personal reasons for indulging in behavior or deed which—although not in accordance with the accepted tenets of society—may nevertheless have been of particular importance to the individual. Such an individual may feel justified in lying about the situation and in regarding himself as innocent. May one add to the four freedoms, the freedom to lie? I understand that in some cultures (Oriental) lying is acceptable, honor being more important than honesty.

On the assumption that man is a free, responsible agent, the law feels justified in punishing, such punishment being presumed to act as a deterrent. It is, however, a historical fact that, for the most part, punishment has failed as a deterrent, and precisely for the reason that the law was not differential in its understanding of the offense—nor did the law attempt to understand the motives behind the deed.

Thus, medicine, and psychiatry in particular, submits that man is far from being a free agent; and, in support of this, has brought forth weighty and abundant clinical material to demonstrate that responsibility varies with the individual and with the deed, and that in many instances, while the individual may be objectively guilty, there may have been a number of individual justifying factors which explain the situation. If the ultimate goal of society is its improvement, and law is an agent to promote it, obviously that goal must be achieved through the improvement of the individuals who compose society, and punishment is not always the direct method by which such improvement can be obtained. Indeed, there is much to point to the possibility that punishment administered without regard to the motivations behind a situation may do the very opposite of what is intended; that is, instead of being a deterrent, it may prove to be an incitement to further crimes. It is therefore doubtful whether the rehabilitation of criminals, which is desired by all, can really be achieved by the commonly accepted means unless the law is also willing to recognize and employ some of the newly discovered methods of science.

## VII

It would be a task to stagger a stout heart to attempt to classify lies, for in a sense lying is implicit in the behavior of mankind in general. The following is merely a cursory attempt designed to cover the most general features of the situation.

1. Benign and salutary forms of lying: (a) Not to hurt the other party. (b) To make another person comfortable. (c) "What people don't know won't hurt them." (d) "Where ignorance is bliss, 'tis folly to be wise." (e) "Why should I destroy her illusions?" (f) There is also such a thing as a "love of lying." We often hear the expression, "He would rather lie than tell the truth." The person thus referred to is generally regarded as a habitual liar, and it is generally believed that he takes a positive delight in lying for its own sake. But is there actually such a type, and if so, what is the motivating force behind his deliberate falsification?

2. Hysterical lying—to attract attention, to make others feel sorry for one.

3. Defensive lying: (a) To extricate one's self from a difficult situation. (b) To account for misused time; to cover up thefts; to deny thefts. (c) Fear of punishment—there is a form of lying which results from cowardice—the denial of having done something, springing from fear of embarrassing or punitive consequences. (d) Feigning or malingering. Simulation of disease by deception for the purpose of gaining certain personal advantages.

4. Compensatory lying: (a) To impress people with one's importance. (b) To pretend for one's self greater achievements. (c) To cover up feelings of inferiority. (d) To excel another liar's story. (e) "Keeping-up-with-the-Joneses" motive—the lies of social pretension. This is generally "defensive and compensatory" but certainly not unconscious. Allied to this is lying from shame—"I wouldn't want her to know how poor we are," etc. This is "defensive" but is hardly "compensatory" and certainly not unconscious.

5. Malicious lying—To deceive for profit. There is the calculated, scheming lying of the typical dramatic "villain"—Iago in *Othello*, Edmund in *King Lear*, Uriah Heep in *David Copperfield*.

6. Gossiping—maliciously exaggerating thin rumors or inventing the same for the purpose of hurting a specific person and deriving personal satisfaction from such gossip. Aspersions and in-

situations belong to the same group. These are often motivated by strong personal emotional reasons such as hostility and jealousy.

7. Implied lying—this is a form of lying which consists of merely maintaining silence, of refraining from telling the truth rather than the actual telling of an untruth. It is more correctly called dissembling or dissimulation. A person may say, "I didn't tell you about this before, but . . ." and then proceed to confess some past performance, the absence of your knowledge of which had led you to form an entirely different impression of his behavior than that which is now disclosed by his belated admission of this or that reprehensible action.

8. Love intoxication type of lying—in all love relations, there is universally an "over-estimation of the sexual object." Nearly all love poetry is lying, in the sense of idealistic exaggeration.

"I wonder who's kissing her now,  
I wonder who's teaching her how,  
I wonder who's looking into her eyes,  
Breathing sighs, telling lies!"

9. Pathologic lying as observed in malingering, retrospective falsifications, fantasy and delusional elaborations; perhaps amnesic states, etc.

## VIII

Perhaps the most insidious, even dangerous, form of lying is self-deception, and the greatest harm done here is to the individual himself. It is far more prevalent than is ordinarily supposed. In its milder forms it appears as "kidding one's self," talking one's self into believing that he is better or more accomplished than he actually is. This is not lack of insight, but unwillingness to use it, in order to spare the ego from unnecessary hurt. Further, we have the beguiling of one's self into beliefs recognized as false, yet held on to, in spite of this, because of their intense emotional appeal.

Some people, it seems, do not like their original selves but want to believe that they are different. They often seek to escape the consciousness of inferiority or defeat, and try to talk themselves into believing that they are better than they actually are. Sometimes they are successful to the point where they actually convince themselves of their fancied superiority or success and behave accordingly.

An unwillingness to admit defeat in achieving a certain objective will lead some people to develop a "sour grapes" attitude, as a result of which they talk themselves into believing that they didn't want the thing to begin with or that it really wasn't worth striving for. Little boys who are too shy to meet little girls, will sometimes tell themselves that they really don't care for them at all, that in fact they hate them, preferring their books and studies, which even on the surface appears a palpable lie, easily seen by others though not by the subjects. In adults this is strikingly evident in cases of refused love, where the rejected suitor suddenly falls in love with somebody else as if to prove to the first love that she was not at all important.

Where is the difference between an honest wish and a lie? If one forgets, or tries to forget, that which it is unpleasant to remember, is this willful self-deception or a state of amnesia? Some people will not allow themselves to discuss sex—as if the subject did not exist. Is not this tacit lying?

Much has been said in psychoanalytic literature about repression. Repression may be successful or it may fail completely. It may be only partially successful; the individual may desperately strive to drive the memory of an unpleasant situation out of his mind, yet not succeed fully, the bitterness of the memory returning ever so often to the surface. However unwilling, he may be forced to face reality. But there is little doubt that the man is trying to hide the true situation from himself; that he is indulging in self-deception.

If one is willing to accept the idea of subconscious lying, he may go further and find that there may even be unconscious lying. Certainly rationalizations are deceptions, but deceptions practised at the unconscious level.

## IX

From the standpoint of psychopathology, lying may properly be viewed as a memory disturbance. It is therefore desirable to correlate it with, and differentiate it from, other and grosser memory disturbances: confabulations, retrospective and other memory falsifications, states of amnesia, and hypermnnesia, pseudologia phantastica, pathological lying, etc.

(a) *Confabulations*. These are the compensatory filling of memory gaps created by the damaging influence of an active, chiefly organic or toxic, psychosis. They are usually associated

with Korsakoff's psychosis but are found in general paresis, senile dementias, and other psychotic states. Somewhere in his personality, though mainly in the unconscious, the individual appreciates that his memory has suffered damage, that isolated events and sometimes even whole blocks of events have been blotted out; whereupon he proceeds to fill the existing memory lacunae by free invention. These fabrications and pseudo-reminiscences, though occasionally becoming quite fixed, are as a rule very fleeting and unstable, changing not only from day to day but indeed from moment to moment, not to be repeated again but substituted for by entirely different ones. Their volatility is evidenced by the fact that confabulatory patients can be guided, directed and re-directed by the observer into all sorts of channels. Yet throughout it all, one discerns a common denominator, a desperate attempt to cover up a most embarrassing life aspect. Because these confabulations endow fantasy with reality, yet have no perceptible connection with, or basis in, the reality of any actual experience, they may be termed memory hallucinations (Bleuler).

Not everyone who has this type of memory disturbance will resort to confabulations. It is indulged in by certain types of personalities too sensitive to face inferiority and who, therefore, are forever on the alert to build and erect compensatory defenses. The organic or toxic condition acts here merely as a precipitating factor, bringing to the surface those inadequacies and limitations which heretofore have been latent because the patient, still being normal, has been able to repress adequately and prevent them from coming to the surface. With the onset of the disease process, the personality becomes insecure, repression less effective, emotions more labile and mobile, with the gradual emergence of the heretofore existing limitations into the open, and the consequent psychic need to dispose of them. Hence, there are confabulations, which assume the character chiefly of compensatory reactions.

(b) *Retrospective Falsifications.* As if not satisfied with pathological distortion of present reality by means of delusions and hallucinations, the psychotic will often resort to including in a system events of the remote past, projecting his false beliefs even as far back as earliest childhood. Let us take a patient whose psychosis became overt at the age of 35. To the best available information, and to all appearances, he seemed entirely well at 30, 25, 20, etc. Yet by the time he came to psychiatric attention at 35, he

gave an elaborate account of abnormal events dating back into his childhood. Events are recalled that never happened (paramnesia), and for that matter never could happen. Single happenings are suddenly given a strange and mysterious explanation. And if these statements are not accepted, the patient will cite new material in their support, an endless procedure if one ever tries to get to the bottom of it.

In neuroses, this behavior finds its parallel counterpart in fantasies of other than known parental origin, of being a changeling, etc.

(c) *Amnesia*. In hysterical amnesia, one often observes that a whole set of events with a large but unpleasant emotional tone is driven out of consciousness. In the global type of amnesia, everything pertaining to the particular painful event (e. g., murder) is excluded from the conscious horizon (katathymic amnesia). To support this amnesia, the patient will either not fill the void at all, claiming that he just cannot recall the event, or else by means of delusions and hallucinations, support the entirely delusional idea that the event never took place. The actual event has been repressed and is kept repressed because the conscious finds it too painful to face the actual situation. In psychoses, states of delirium are often followed by amnesia, though the events themselves are not particularly important.

The amnesias need not necessarily be complete or fixed. Ever so often the repressed event may emerge to the surface, only to disappear again. Amnestic material sometimes reappears in dreams. Amnesias are not to be confused with other memory disturbances: disturbances in retention such as are found in organic and toxic psychoses; memory weakness, which may be genuine because structural, in organic psychoses, or again entirely functional, even psychogenic, in schizophrenias.

(d) *Hypermnnesia*. As contrasted with amnesias, we have hypermnnesias in which certain events stand out or are recollected with particular clearness and vividness both as regards their general occurrences, as well as to the recollection of details ordinarily little noticed. We find this observed in dreams, hypnosis, delirious states, etc.

(e) *Pseudologia Phantastica*. This is (at the conscious level) a seemingly purposeless prodigious compensatory falsification that does not appear opportunistic or defensive but is rather com-

pulsive in character and is not accompanied by a pleasant feeling tone. It stands by itself as a special trend in the personality of the particular individual, though it may be tied up with other abnormal mental states, to wit, psychoses, and, particularly, neuroses. There is first of all, in pseudologia phantastica, a most pressing need to indulge in extravagant castle-building to make up for a reality that appears to the patient to be too prosaic. Undisturbed, these patients live in a dream world. Nevertheless, even with a prodigious and vivid utilization of exuberant fantasy weaving, generated by unconscious forces, the pseudologue is not entirely unaware of the fact that the whole thing is a fabrication, pure and simple. This is not at all true of confabulations, states of paramnesia and retrospective falsifications. Confronted by facts and events which contradict his fantasy, the pseudologue will readily admit the true situation. In the manner of the hysteric, of which he is but a subtype, and who though blind, yet may see when necessary, the pseudologue is still in touch with reality. The pseudologue may be regarded as the functional psychic parallel of the confabulator whose memory gap is organic. He differs from the confabulator, in that his basic memory is structurally intact but memories are freely invented to satisfy pressing psychological needs. Further, while confabulations are built on memory defects, and paramnesias follow amnesia or other memory disturbances, free invention in pseudologia phantastica is indulged in entirely to satisfy specific psychological needs.

In a sense, pseudologia phantastica may be viewed as verbally *expressed* day dreams and as in day dreams, the patients half believe their own fanciful tales. Theirs is an unusually rich imagination prodded into active expression by acutely-felt psychic needs. They recite tales of socially exalted backgrounds which provide the glamor for which they seem to feel a strong need, or will recite sad stories, calculated to arouse great pity. This is an expression of a particular type of neurosis, and a study of the life history of patients suffering from it reveals the presence of other trends indicative of neurotic make-up: marked egocentricity, high suggestibility, unreliability, a pathological need for self-assertion, a precocious sex life (masturbation and perverse trends) and marked emotional conflicts about these. How, for instance, is one to interpret false accusations of incest by a girl against father and

brother (Healy's Case No. 16) except as inverted wishes on the same level with hysterical fancies of violations and rape?

Pseudologues have little or no insight into real behavior or into the harm they may cause others. They all are glib talkers, really artists at fabrication, and their recitals give strong impressions of verisimilitude. Characteristically, as noted by Healy, they show a remarkable aptitude of language. They are good conversationalists and are good at composition writing.

According to Healy<sup>2</sup> pseudologia phantastica is a type of delinquency and leads to false accusations and swindling, and is therefore important from the standpoint of forensic psychiatry. This should be separated and differentiated from purposeful lying that is within the limits of the normal. Such false accusations as may be purposeful and indulged in because of vindictiveness, grudge-formation, or as a means of getting out of difficulties, or which disguise undesirable truths, are not, according to Healy, related to pseudologia phantastica.

(f) *Pathological Lying*. From the classification, pseudologia phantastica, it is desirable to split off pathological lying as a separate entity. Unlike pseudologia phantastica, it is not compensatory or wish-fulfilling in character but entirely defensive: (a) to cover undesirable facts and events that will not stand well the light of day, (b) to protect or safeguard a difficult situation, (c) to avenge a hurt, the individual going almost recklessly to no end of lying in order to satisfy a hostile feeling. Unlike pseudologia phantastica, pathological lying is of a more conscious, more deliberate nature, although the need for resorting to it stems from the deeper reaches of the personality. The pathological liar may—like the pseudologue—want to provide a nicer background in place of one that is sordid, or substitute a different event for one he would prefer not to admit, but in contrast to the pseudologue this is done in greater moderation and quite within the limits of reality. It is probably identical with the term chronic prevaricator which Healy regards as falling within the limits of the normal, but which in our view, is definitely abnormal.

## X

To the psychiatrist, lying is of particular importance, for he meets it daily in his work, whether in its direct and unblushing form or in the form of unwitting evasions or rationalizations. How is he to deal with such material? Is he to accept the state-

ments of the patient at their face value or give them only limited credence; and how is he to define this limited credence? What is he to take and what is he to discard? Is he to keep on questioning the individual who is so obviously falsifying the truth or inventing situations that never existed? This may be an endless procedure, for in the case of an expert liar this can only mean more lies heaped upon many previous ones.

As a rule, the truthfulness of psychotics can be relied upon. The dementia praecox patient usually will not lie. Though he may appear to be evasive, this is, perchance, caused by memory or association disturbances. He may be telling what appears to be an untruth, whereas in reality he presents only a symbol which, if properly de-symbolized, may well be the truth. He may be asked how he feels, and although he is obviously depressed or apathetic, he may answer that he feels quite well. This, however, rather than being an untruth, is more an expression of disharmony of mood, a clinical symptom rather far removed from lying.

The manic, in an elated stage, because of his volubility and exuberance, may exaggerate or minimize the real truth of situations, but this can hardly be called lying. The paranoiac may give expression to many delusional ideas and retrospective falsifications, but these have long passed the stage of conventional truth-distortion and have assumed entirely the aspect of delusional psychotic elaborations.

It is with the neurotic and the psychopath that we are likely to have most trouble in respect to lying. Unlike the psychotic, the neurotic is in too close touch with reality; and, while he may be deeply absorbed in fantasy, he knows somewhere, even if it be only from the corner of his eye or the fringe of consciousness, how much of what he says is true and how much of it is false. When he is put in a position of defense he will not hesitate to lie, but most of his lies may well be benign lying, a defensive or compensatory feature of his neurosis. He may resort to more malignant lying, however, when his behavior is motivated by hostility or other antipathic emotions, in which case, swayed entirely by these emotions, he is likely to lie in order to satisfy the hostility. Malicious gossiping is perhaps a good instance of this. Or the neurotic may be involved in numerous difficult situations from which he may want to escape, in which case his lying may assume a definitely psychopathic character.

But it is in the case of the psychopath that the psychiatrist has the greatest difficulty with lying, and nowhere is it found more frequently than in prisons. Getting information from an imprisoned psychopath presents many difficulties; by and large, he has been in trouble all his life, and there is much that he would like to hide or defend and much that he would like to escape. He wishes to escape the consequences of his deeds, including punishment, not only because, like any human being, he does not like restrictions of any nature, but because he is so absolutely lacking in any sense of guilt that he does not consider himself wrong. Therefore, he feels fully justified in telling all sorts of lies in order to escape the consequences of his past behavior. It is a most difficult task to obtain any true information of value in the case history of a psychopath. Even when confronted with reliable corroborative information from other sources, he will persist in his original statement and will attempt to confound us with still more lies. Not only does he lie about the existing situation which has gotten him into difficulties, but he is equally disposed to falsify his background in an attempt to create a favorable impression on the examiner. Such falsification may at times approach that seen in Korsakoff's psychosis.

Almost any emotional state which is inadequate and is reacted to incompletely may lead to lying, but foremost among such states are feelings of inferiority, insecurity, unrequited love, hostility and, most of all perhaps, that great ubiquitous plague, guilt; especially unconscious guilt. Guilt is probably the greatest emotional scourge of mankind. From cradle to grave it is at once creative and destructive, responsible alike for much in our loves and hates, our lies and truths, for ruthless aggression and most abject humility, for many murders and suicides, as well as for much normal and distorted human behavior. It is as much a cause of religion as of atheism. Rather than sequence-guilt, unconscious guilt certainly may have been the prime force behind the origin of religion.\*

\*It is extremely suggestive that although the problem of guilt plays a large part in neuroses and in the daily work of psychoanalysts, the literature on the subject is very meager. To be sure, many articles make passing mention of the subject and here and there one finds an article especially devoted to its discussion, but there are no books taking up the subject as a whole. I know of only one recent publication, namely Bergler's *The Battle of the Conscience* that discusses the subject in an adequate and competent manner. In Saul's book, *Emotional Maturity*, there is a sound and confidently written section on guilt.

Yet since these same emotional states, including guilt, do not in other individuals under like circumstances lead to lying, it must be concluded that behind lying stands the liar, a particular type of personality that cannot face or accept reality, but must distort it to meet his special needs. In such personalities lying is motivated by specific psychological constellations, unconscious in character: It satisfies specific emotional needs which not only determine lying as an outlet, but likewise the type and content of such lying. The circumstances under which the individual lies; why one individual in the face of a difficult situation will resort to lying while another under like circumstances will stubbornly tell the truth and brave any untoward consequences, are again matters of personality. The intriguing question thus presented is: truth versus lying and reality versus fantasy. Of course, a liar is not necessarily a liar at all times. Many individuals—perhaps most individuals—may indulge in lying on some occasions while they are quite truthful on others.

Thus, every neurotic and every psychopath tells his own type of lies, a type which fits in with his background and personality. The lie that will fit one individual will not fit another at all and therefore cannot be used by another individual. Before the lie is verbally expressed, the individual has at his disposal several other choices, and the expression finally chosen is overdetermined. In some cases it may well have undergone a transformation from the original; and the lie, therefore, may be a reaction formation, that is, a reversal of the original trend. In other words, free and uninhibited as lying may appear to be, it is basically well controlled by psychic processes of which the individual has no specific knowledge and over which he has no control. Because of these considerations, we must view lying as a product of unconscious mentation; and the unconscious does not lie. Hence, regardless of how clever the individual liar may be, he unwittingly and unconsciously reveals himself through his lying. Like dreams and fantasies, to which they are closely related, lies have a structure of their own and a careful analysis of them should reveal clearly the man behind them.

If now the tenet be accepted that lies are products of repressions and are unconsciously motivated, it will now have to be granted that there is a most definite correlation between them and the life of the individual. The more we let the individual talk, the more

likely he is to produce sufficient material which, even though it be in the form of lying, will somewhere definitely relate to the true situation. Indeed this is the very approach used universally in psychoanalysis. However honest a patient may be, he unwittingly indulges in all sorts of distortion which the treatment is later able to correct. Therefore, a psychiatrist oriented in a psychodynamic focus should have less difficulty in interpreting the meaning of lies in the life of the individual than the psychiatrist who works merely at the descriptive level. By a careful analysis of the lies the dynamic psychiatrist should be able to uncover much of the true situation and arrive at the dynamics of the very lies to which the individual has resorted.

#### SUMMARY

In our modern culture, honesty is considered more important in human relations than either knowledge or beauty. Accordingly, lying, in its many varieties and types, is regarded as most reprehensible and as the core of all human vices.

Withal, however it may be disguised by the thin veneer of social conventions, lying permeates our daily life, personal and social. Be it in interpersonal relations, relations between the sexes, professional, commercial, economic, political, national and international relations, our life is filled with lies and deceptions; and the line dividing this from anti-social and criminal reactions is often a very thin one. Indeed, lying may be regarded as integral to honesty and essential to it as a necessary complement.

Our mode of living not only allows for, but actually creates, many situations, which make lying absolutely necessary if people are to get along socially. Our cultural imperative is to repress the basically true and to express the socially desirable even if untrue; for our primitive urges, if uncontrolled and uninhibited, would not have allowed the formation of a well-functioning social order. To wit, politeness, which is so important in our interpersonal relations, is yet undoubtedly a form related to lying.

Lying has a long and colorful human history dating to the belief in magic in prehistoric man. It goes even beyond that for deceptions are not unknown in the animal world.

Like other forms of human behavior, lying is not entirely conscious, or deliberate. In its more overt form, it has all the earmarks of a neurotic symptom, a part of the general neurotic con-

stellation. It is often resorted to as a defense against feelings of insecurity and inferiority.

Many lies are products of repression and are unconsciously motivated. The consideration of lying as such is meaningless unless one recognizes the motivation behind lying. Lies are differential; they are psychological reactions that are highly specific for each individual.

The interests of the two professions, law and medicine, are in a large measure contiguous, though the viewpoints are often opposite; and this appears clearly in consideration of lying. Our early training of the child has for its purpose the development of a conscience and a sense of guilt, a ready obedience to dictates of culture (duty). While this training succeeds in most cases, it fails in others, resulting in anti-social and criminal behavior. It is here that law steps in, in principle condemning lying as inimical to the establishment of truth and demanding truth and nothing but the truth. On the other hand, medicine, concerned primarily with the welfare of the individual patient, cannot regard truth as an absolute goal and lying as an evil *per se*, but only considers these matters to the extent that they affect the individual patient.

In yet another situation, law and medicine appear to be at odds. The law recognizes only the deed, not the motivation behind the deed. It further recognizes personal guilt, free will and personal responsibility, which it expects the individual to acknowledge freely and unequivocally; and law exacts punishment as a sure deterrent. Medicine, on the other hand, recognizes etiology, development, and pathology behind the symptoms displayed. In recognizing these, the psychiatrist may uncover deep-seated reasons behind a man's lying, reasons which may have their full justification in the light of the individual's life history, to be understood rather than condemned. Nor can psychiatry view man entirely as a free agent, fully responsible for his behavior.

In general terms, lies may be classified as benign and malicious; hysterical, defensive, and compensatory; gossiping, implied lying, lying in love relations, and pathological lying. A most insidious form of lying is self-deception which is most often subconscious. Certain deceptions are practised at the unconscious level, e. g., rationalizations.

From the standpoint of psychopathology, lying may properly be viewed as a memory disturbance and therefore has relation to such

reactions as confabulations, retrospective falsifications, amnesic states, pseudologia phantastica and pathological lying.

To the psychiatrist, the consideration of lying is of importance in the study and treatment of patients. Psychotics as a rule do not lie. The schizophrenic will not lie, however evasive he may be; unwitting falsifications may occur because of memory and association disturbances. The manic individual may suppress the truth or exaggerate the real situation depending upon the mental stage. The retrospective falsifications of the paranoiac are as unconscious as are confabulations and amnesias. Neurotics may lie defensively or compensatorily or for reasons of hostility. But it is the true psychopath that is the liar *par excellence*, because his life is full of misdeeds and grosser anti-social and criminal behavior, against the discovery of which he protects himself by lying. He often lies beyond the need of the situation and such lying sometimes assumes the character of pathological lying. Rather than viewing this lying as an obstruction to the understanding of a case, the psychiatrist will discover the motivations of the personality by an analysis of the lies themselves.

St. Elizabeths Hospital  
Washington, D. C.

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## A REVIEW OF 27 PREFRONTAL LOBOTOMY PATIENTS

BY HERMAN B. SNOW, M. D.

There have been many papers written about prefrontal lobotomy and a book on the subject\* by Freeman and Watts has appeared. This book describes in great detail the history, method, indications and results. It is not the purpose of this paper to review the pertinent literature or to go into lengthy discussions regarding the operative procedures. It is merely the aim to report the clinical results which have occurred in 27 Binghamton (N. Y.) State Hospital patients who were operated upon between May 27, 1946, and December 17, 1947. The evaluation was made as of June 15, 1948. Psychological material was not studied.

All of the operations were done by J. Worden Kane, consulting neurosurgeon to Binghamton State Hospital. He used the procedure described by Freeman and Watts in their book—the lateral approach.

At Binghamton, the criteria for selection of patients were limited to the following: (1) assaultiveness to such a degree that almost constant restraint was necessary; (2) excitement; (3) destructiveness of clothing and furniture; (4) observation of such behavior over a period of several years; (5) no doubt that the patient's prognosis was hopeless.

There are a few facts in general that should be mentioned at this time. The ages of the patients vary between 21 and 66, with the average 37 and one-half. Length of hospitalization varies from three to over 20 years. There is a predominance of women (21) in this group—but only by coincidence. Table 1 shows in detail the date of operation, age of the patient, diagnosis and condition. The diagnoses vary as is shown in Table 2. It is felt that the series is too small to make any definite statements from these tables.

After operation, all the patients, as far as possible, were placed on habit-training wards where an effort was made to help readjust the patients in eating habits, dress and recreation. They attended occupational therapy and the women made visits to the beauty parlor.

\*Freeman and Watts: *Psychosurgery*. Charles Thomas. Springfield, Ill. 1942.

## CASE REPORTS

The following histories are illustrative of the typical cases which were operated upon.

S. K., No. 2 in Table 1. This is a colored patient who was born about 1905, in Virginia. She reached the fourth grade at 11 years of age. She had been married once and had two children. She was said to have been religious, had many friends and got along very well. Toward the end of 1938, the patient fell, hurting her leg, but did not bother with this until a few days later when she went to see a doctor. That night, in January 1939, she suddenly became very excited and said there was something in the room and that she had to run away. She began to scream. She was taken to Bellevue Hospital and then transferred to Central Islip State Hospital on January 3, 1939. There she was described as follows: Her stream of mental activity was rambling but relevant; affect and mood were flattened and inappropriate; her trend consisted of delusions of persecution in that she felt people were trying to hurt her in some unknown way. She was found to have syphilis and was treated for it. The continued notes at that hospital showed that she was "quite irritable and assaultive—very excited and almost antagonistic, over-productive, rambling, disjointed in her speech, refused to do any work."

She was transferred to Binghamton State Hospital on June 3, 1941. During the five years at that hospital, she was unco-operative, distractible, irrelevant, untidy and manneristic. She was angry, resentful and explosive. She did not mix with the other patients, was frequently impulsively assaultive; and she wet and soiled. Her table manners were extremely poor. She would steal other patients' food at the table and dump it on the floor. A typical restraint record for the month of January 1946, shows: camisole restraint for 19 hours each day for 22 days; and for six hours, and for 13 hours on two other days. She was diagnosed as dementia præcox, paranoid type.

The duration of her illness was seven years and six months, dating from the onset in January 1939 to July 15, 1946, when pre-frontal lobotomy was performed. During the operation, the patient showed no remarkable change. For a few days afterward, she was rather unco-operative, pushed the furniture around and was inclined to be a little irritable. She was transferred to the habit-training ward where for a few weeks she urinated on the

floor. However, it was soon noticed that her poor eating habits had disappeared. She ate in a very orderly manner, was co-operative and showed no irritability. She began to dress very neatly and did not require restraint after the operation. She attended the movies, went to the dances, worked in the kitchen cutting and preparing vegetables or washing dishes. She did not usually engage in conversation but seemed well aware of what was going on about her in the kitchen. On occasions she would pass a very witty remark apropos of some conversation. She helped spontaneously with many tasks about the kitchen, showing some initiative. On January 29, 1948, she was placed on convalescent status. Since then she has been doing regular housework at home, goes to church, and likes to mingle with people, although she remains a better listener than talker.

M. W., No. 3. This male patient was born February 12, 1913. His diagnosis is dementia praecox, catatonic type. He finished four years of high school at the age of 18. After school, he taught violin and was described as an excellent violinist as well as a good teacher. He had an even disposition, was ambitious and seclusive. He went to Bible Training School in 1935, and shortly thereafter he began to hallucinate music and the devil's voice. Following this, he refused to eat or go to bed and had frequent crying spells. He was committed to Binghamton State Hospital in April 1936 where he was very negativistic, requiring tube feeding. He wet and soiled, hallucinated, then began to show impulsive behavior by throwing himself to the floor. He improved slightly, was paroled January 10, 1938 and discharged one year later. At home, he did not attempt to find any work, assumed rigid positions, showed irritability and appeared despondent at intervals.

M. W. was certified again in July 1943, because he began to state it was necessary "to shoot his parents to save them." He received shock therapy treatment and for a while showed excellent improvement and then quickly became blocked, mute, refused to eat, was resistive and finally became assaultive and destructive. He would throw himself on the floor or at other patients and employees and had to be tube fed daily. A typical restraint record—for January 1946—shows 19 hours in restraint for 31 days. The duration of illness was 10 years and five months, dating from the onset in April 1936, until the lobotomy operation in September 1946. This patient, during the 10 years, had shown some im-

provement in behavior for short periods, but for three and a quarter years before the operation, had shown nothing but increasingly assaultive behavior.

His weight in August 1946, just before the operation, was 105 pounds, in September, after the operation 116½ pounds, and in February 1947, 177½ pounds. For approximately 20 days after the operation, he continued to wet and soil on occasion. He would say, "Hello," or shake hands now and then, which had been unusual for him, and he began to feed himself. He was no longer assaultive and needed no restraint. A note by his ward physician described the patient "as being mildly negativistic, not impulsive or annoying to the others, is much easier to care for and he seems to take a little more interest in what goes on about him and recently has begun to play his violin again. Although still not spontaneous, he does respond to questions in a more easy, relevant fashion than formerly. Whereas previously he was quite untidy both in his habits and personal appearance, there has been considerable improvement in this respect. He does some light tasks about the ward, occasionally showing initiative and at other times having to be urged or persuaded." M. W. continued to improve and was placed on convalescent status on August 18, 1947. He was interviewed recently by a staff physician who stated that "the patient was more spontaneous in conversation, did a great deal of work about the farm, was well dressed and alert."

O. F., No. 20. This patient was born December 12, 1902, in Texas. Nothing unusual is known of her early life. She completed grammar school at the age of 13, then worked as a domestic. She married at the age of 20, but her husband deserted her. She came to New York City in 1929, and worked as a maid. She liked to attend dances and movies; but, although she was sociable, she never spoke to anyone about her affairs. In 1934, the man with whom she was living deserted her. She began to eat poorly, knocked at neighbors' doors and left before anyone answered, expressed fear of the dark and fear that some one was putting a "hoodoo" on her.

At Kings Park State Hospital October 31, 1934, O. F. assumed uncomfortable attitudes, stared about her with a blank expression, and confided that she heard the voice of her mother who had died years before. During her stay at that hospital, she had periods of violent, impulsive activity alternating with mutism. She fre-

quently attacked other patients and was destructive to furniture and clothing. She required restraint frequently. She was transferred to Pilgrim State Hospital. There her impulsive, assaultive periods made it necessary to keep the patient in restraint much of the time. She had a short course of electric shock therapy following which she became quiet and more amenable. She hallucinated voices of a paranoid nature.

On June 3, 1941, O. F. was transferred to Binghamton State Hospital. For the next six years, her behavior was characterized by sudden, impulsive, violent attacks on other patients and employees. She declared she heard the voices of a man and a woman who were trying to poison her mind. If allowed the opportunity, she would pick up furniture and throw it at the nearest person. She was sly and cunning. She almost choked an attendant to death at one time and was tremendously destructive. Finally steps were taken to transfer this patient to the Matteawan State Hospital for the criminally insane. About this time permission for prefrontal lobotomy was obtained, and the operation was performed on October 7, 1947. Following this, the patient became quiet, pleasant, agreeable and co-operative, although, because of her past performances, the nurses and attendants were always extremely suspicious of the patient's slightest move. However, after three months went by and it was seen that the patient would read or engage in occupational therapy activities without causing any difficulty, she was taken to church, movies, on walks and so on. After the operation, she never required any restraint, never made any untoward move. She responded to questioning in a simple way, with a smile but always briefly. In May 1948, in an interview, she stated that she remembered all her violent behavior and could give no reason for it except that she had been afraid she was going to be killed or poisoned. She was approximately oriented. She was neat and tidy about her person. On May 19, 1948, she was placed on convalescent status and returned to her home in Texas. She was on the train for four days and three nights and got along very well, and without any difficulty. Her condition on leaving the hospital was considered much improved. (A letter received July 12, 1948, from her attending physician in San Marcos, Texas, states, "I have observed your patient . . . twice in the past two months and I believe that the result in her case has been highly successful. She has been in excellent general health since arriv-

ing here and her mental condition has improved to normal. She is leading a very normal life at the present time, keeping house, cooking, attends church, enjoys reading, movies, etc. She has had no sign of any irritability or tendency towards seizures. She is totally oriented now and even talks intelligently about her past illness and highly appreciates her remarkable recovery. . . .")

Table 1 shows some of the pertinent information in regard to all 27 patients. If the reader keeps in mind that all these patients were of the destructive, assaultive type, the short comment—as for example after patient S. K., No. 8, has more significance. This particular man now goes about the grounds with his mother on her weekly visits. He walks with her in a very natural way, carrying on a fair conversation. Previously he could not even be kept in clothes because he would destroy them quickly.

Table 1

	Age	Diagnosis	Date of operation	Remarks	Condition*
1—M. C.	26	Psy. Epi. Enceph.	May 27, 1946	Unimproved. Re-operated June 4, 1946. Behavior remarkably improved. Died June 13, 1947, of lobar pneumonia.	I
2—S. K.	41	D. P. Par.	July 16, 1946	Improved remarkably. Convalescent status since January 29, 1948.	I
3—M. W.	33	D. P. Cat.	Sept. 19, 1946	Greatly improved. Convalescent status since August 16, 1947.	M I
4—T. P.	48	Man.-D. M.	Nov. 22, 1946	Quiet, no restraint, no profanity.	I
5—C. C.	21	D. P. Heb.	Jan. 28, 1947	Unimproved. Re-operated July 15, 1947. Improved for short period then relapsed to previous behavior.	U
6—A. M.	44	D. P. Cat.	Feb. 7, 1947	Not destructive to clothing, better eating manners.	I
7—I. B.	24	D. P. Heb.	Mar. 14, 1947	Periods of improvement. Relapsed to same condition.	U
8—S. K.	30	D. P. Par.	Mar. 14, 1947	Not destructive to clothing or furniture. Well dressed, visits well with relatives.	I
9—F. B.	38	Man.-D. M.	May 27, 1947	Improved greatly. Convalescent status since March 12, 1948.	I
10—B. G.	56	Inv. Mel.	June 9, 1947	Improved greatly. Convalescent status since July 16, 1947.	M I

\*Key—"I" improved; "M I" much improved; "U" unimproved.

Table 1—(concluded)

	Age	Diagnosis	Date of operation	Remarks	Condition*
11--A. B.	31	D. P. Cat.	June 16, 1947	Unimproved. Re-operated December 22, 1947 and then improved remarkably. Convalescent status since June 7, 1948.	M I
12--J. D.	26	D. P. Heb.	June 23, 1947	Improved greatly in behavior.	I
13--L. A.	36	D. P. Par.	July 1, 1947	Shows some improvement but not enough to call her "improved."	U
14--G. M.	52	D. P. Par.	July 1, 1947	Unimproved. Re-operated May 25, 1948. No change.	U
15--C. H.	40	D. P. Cat.	July 24, 1947	Unimproved	U
16--L. T.	48	D. P. Heb.	Sept. 19, 1947	Improved in behavior and habits.	I
17--S. E.	34	D. P. Heb.	Sept. 19, 1947	Improved very well. Convalescent status since June 15, 1948.	I
18--G. T.	66	Psy. Ment. Def.	Sept. 30, 1947	Unimproved.	U
19--M. E.	45	D. P. Par.	Oct. 7, 1947	Unimproved.	U
20--O. F.	32	D. P. Cat.	Oct. 7, 1947	Patient was scheduled for Matteawan. Improved remarkably. Convalescent status since May 19, 1948.	M I
21--M. O.	32	D. P. Heb.	Oct. 14, 1947	Improved greatly. Convalescent status since March 7, 1948.	I
22--R. G.	58	D. P. Heb.	Oct. 14, 1947	From a seriously assaultive and destructive problem now is neat and tidy and works in the kitchen.	I
23--M. C.	33	D. P. Heb.	Oct. 28, 1947	Severe behavior problem has now become improved and has been approved for convalescent status.	I
24--C. I.	28	D. P. Heb.	Oct. 28, 1947	No change.	U
25--A. R.	29	D. P. Cat.	Nov. 20, 1947	No change.	U
26--W. C.	39	Psy. Epi. Enceph.	Dec. 9, 1947	Has shown some improvement but not enough.	U
27--J. B.	24	D. P. Cat.	Dec. 17, 1947	Has stopped picking her skin but otherwise no change.	U

\*Key—"I" improved; "M I" much improved; "U" unimproved.

The table also shows that five patients underwent re-operations. There had been no improvement after the first operation. The neurosurgeon then tried to make his incision more posteriorly and more complete than in the first operation. No neurological disturbances were noted after either operation.

Table 2 shows the results of the operation in the various diagnostic groups. This series is too small to make any claims for one group over another. It is the writer's opinion that the type of psychosis from which the patient is suffering is not in itself a clue as to the post-operative prognosis.

Table 2

	Unimp.	Imp.	Much imp.
Psychosis with epidemic encephalitis .....	1	1*	.
Dementia præcox, paranoid .....	3	2	.
Dementia præcox, catatonic .....	3	1	3
Dementia præcox, hebephrenic .....	3	6	.
Manic-depression, manic .....	.	2	.
Psychosis with mental deficiency, excitement .....	1	.	.

\*Died of lobar pneumonia one year after operation.

Table 3 is a total picture of the post-operative results. It is remarkable that out of a group of 27 deteriorated, destructive and assaultive patients operated upon, patients for whom everyone had lost hope, we should find eight now at home and a ninth on her way home. This was beyond anyone's expectations. In this series, it should also be noted, there were no post-operative deaths.

Table 3

Total	Unimproved	Improved	Much improved
27	11	12*	4†

\*Four patients in this group are now at home on convalescent status; a fifth patient has been approved for convalescent status but is awaiting arrival of her relatives.

†All four patients are now at home.

### SUMMARY

1. Prefrontal lobotomy was performed on 27 patients who were considered hopelessly psychotic and beyond any help.
2. Twelve patients improved and four were much improved. Of these 16 patients, eight are at home, and the others are helpful about the ward in one way or another.
3. Eleven patients did not benefit by the operation.

## CONCLUSION

Prefrontal lobotomy is not advocated as a routine hospital procedure for the cure or alleviation of the acute psychosis. All other forms of therapy, plus a reasonable length of time, should be given before this heroic type of treatment is attempted. It certainly is of definite therapeutic value in the chronic cases of long standing—who are the forgotten people in psychiatric therapy because everyone wants to treat acute cases. With the use of prefrontal lobotomy, we can look forward to saving a moderate percentage from the camisole, restraint sheet or seclusion room. Many of these individuals can again enjoy social relationships with their families and friends, taking pleasure in recreational activities to a greater or lesser extent, even though they retain some of their psychotic manifestations.

Utica State Hospital  
Utica 2, N. Y.

## ON THE STRUCTURE AND DYNAMICS OF SUPERVISION IN PSYCHIATRIC TRAINING

BY EDWARD STAINBROOK, Ph.D., M. D.

Near the middle of the nineteenth century the Austrian medical psychologist, Baron von Feuchtersleben, was sufficiently sensitive to the meaning of the psychiatric therapeutic process to insist that, "Since in the so-called psychical mode of cure, one personality has to act upon another . . . the treatment in most instances demands a second education of the physician." This is a remarkable statement to have been made a hundred years ago at a time when psychiatry was just beginning to be established as a medical science. Von Feuchtersleben was expressing a clear recognition of the value of what is now familiarly called psychotherapy, although, it is true, Johannes Reil, among others, had earlier employed an "argumentative" psychotherapy to treat the mentally disordered and had desired that in every asylum the physicians should have as assistants "a moralist and an ideologist."

Equally as important as his stress on the "psychical mode of cure," however, was the mention by von Feuchtersleben of the necessity of a "second education" for the physician who was to become a psychiatrist. The methods by which medical education has attempted to structure this "second education" in psychiatry have a long history of varying execution and culminate in the present conceptions of what training in psychiatry should be.

Contemporary psychiatry is considerably burdened by urgent demands from both undergraduate and graduate medical education for adequate instruction in the knowledge of disorders of behavior. In the undergraduate area, extensive revision of the content and methods of psychiatric teaching is now taking place. This undergraduate revision is in the direction of a more intimate integration of psychiatry with the other divisions of medicine. The emphasis is being placed upon the genetic-dynamic understanding of the determinant, concomitant, reactive, or resultant psychopathology of disease. The doctor-patient relationship, too, is being subjected to psychodynamic study, and contemporary medical instruction is taking cognizance of the necessity of specifying how the psychology of the physician is involved in patient treatment. Finally at long last, psychiatric education in the medical school is beginning

really to fulfill its task of demonstrating the human "dys-ease" in disease and of communicating formulations of psychotherapeutic and other psychiatric treatment which doctors other than psychiatrists may use along with psychodynamic insight into their own feelings about the patient's illness.

Most unfortunately, however, the graduate training of the psychiatrist, the structure and content of von Feuchtersleben's "second education," is currently rather disorganized. If, on the undergraduate level, psychiatry can disguise its controversies over theory and practice under the innocuous and superficially inclusive concept of "psychosomatic medicine," no such subterfuge is possible in graduate training where, at the beginning, the choice of a residency also involves, many times unwittingly, the selection and rejection of disparate psychiatric schools of thought.

The existence of so many differently structured psychiatric training places is due largely to the current differences of opinion about what the basic sciences of psychological medicine actually are. For in the last analysis, psychiatric training is concerned primarily with the structure and dynamics of the learning process involved in the mastery of the basic sciences of psychiatry.

Everyone agrees that the basic sciences of general medicine are to be considered also as sciences basic to psychiatry. What, then, creates controversy about what ought to be an obviously simple delineation of the character of the science of psychiatry?

One of the answers to this question resides in the very banal assertion that the events which psychiatric science describes and treats are happenings of behavior. The behaving person is the concern of psychiatry; and the first task of the science of psychiatry, therefore, as certainly Kraepelin understood, must always be the construction and maintenance of an adequate concept-system for describing the person behaving.

Too many young, "psychodynamically-wise" psychiatrists of the present time, incidentally, act as if systems of descriptive psychopathology are a historical phase in psychiatric development with which they need no longer be concerned. Nothing, of course, can be more dangerous to scientific methodological integrity than such an attitude. If psychiatry is to become and remain an adequate scientific discipline each succeeding generation of psychiatrists must have its own Kraepelin.

In contrast to the Kraepelinian emphasis upon the minute description of abnormal behavior, many other adherents of the German somatogenic school which dominated late nineteenth century psychiatry, and which was the forerunner of an obstinately lingering group of contemporary organicists, looked right at behavior but saw only its physiological and structural correlates. Behavior, however, has its own structure and dynamics and it can be talked about only in its own "world of discourse." This "world of discourse" about behavior is the science of psychology, and, more, particularly, largely as a result of the cultural and scientific stimulus deriving from the thinking of Sigmund Freud, this science of behavior may be called, perhaps somewhat tautologically, psychodynamic psychology. Hence, a basic science which twentieth century psychiatry has added to medicine is the science of psychology, or more specifically, of psychodynamics.

Sandor Rado<sup>2</sup> has already established this same contention and has cogently detailed the development and the contemporary meaning of psychodynamics as a basic science. In turning to the essential problem of how psychodynamics is to be taught, Rado, however, insists that "psychodynamics requires a personal preparation by each student: he must first undergo a personal psychoanalysis." Now there is no question that at this time and in the kind of psychiatric training structures that currently exist such a statement is incontrovertible. Unfortunately, if it remains true that psychodynamics can only be learned by undergoing psychoanalysis, then the brute fact exists that only 10 to 25 per cent of the resident psychiatrists in training at any time in the reasonable future will be able to acquire the most necessary basic knowledge of their science. Moreover, although a greater number of psychiatrists are now getting psychoanalytic training than ever before, much of this present learning is made possible by government veterans' subsidization. Later, if the training situation is not re-structured for general education in psychodynamic psychiatry, the selection of residents for psychoanalytic training will of necessity be progressively biased in favor of those who have independent incomes.

However desirable, therefore, it may be to have every psychiatrist undergo a personal psychoanalysis as a learning process for psychodynamic and psychotherapeutic knowledge, it is urgently and realistically necessary to explore other methods for teaching psychodynamics and psychotherapy. It is simply impossible to

provide an adequate psychoanalysis for everyone who will specialize in psychiatry. If we insist upon maintaining such an unrealistic attitude toward psychiatric training, we shall continue to deprive the greater portion of psychiatrists in training of a real mastery of their specialty, and we shall continue the conditions responsible for professional tension between the analyzed and the unanalyzed groups.

How else, then, than by undergoing personal psychoanalysis can the learning process in psychiatry be structured? Obviously this can only be determined experimentally, but we do know that supervised learning of psychodynamics and psychotherapeutic knowledge without a prerequisite personal analysis has been largely worked out in the child guidance field under the aegis of Frederick Allen, John Rose, and others, and, in social work significantly, by the Pennsylvania School of Social Work under the leadership of Jesse Taft and Almena Dawley.

The happy circumstance in psychiatry is that now—and only recently—it is possible for the psychiatrist, like the surgeon, to learn about disease in the actual process of treating it. That is to say, psychodynamic knowledge is to be gained in the process of psychotherapy. Therefore, the basic learning process in psychiatry is the psychotherapeutic process. Additionally, it will be generally agreed that psychotherapy is the major treatment method of the well-trained psychiatrist. The psychotherapeutic experience is, accordingly, the central and basic process in psychiatric training. It issues both in the mastery of the technic of psychotherapy and in the conquest of the science of psychodynamics. It follows inevitably that the psychiatric training structure must be psychotherapeutically centered. This is true even if insulin treatment, electric shock, or prefrontal leukotomy is considered to be a more important treatment concern. Such procedures are exhibited rationally only at a certain phase in a psychotherapeutic relationship—and, as adjuvants, to condition the interpersonal relations of the patient to the therapist and to other people.

The first requisite of the psychiatric training situation, therefore, is that the resident be engaged in an interpersonal helping relationship with patients. The second necessity is the availability of personal supervision for the training resident within the training structure itself. These two requirements, when adequately fulfilled, make possible an experimental training structure for

teaching psychodynamics, psychotherapy, and general psychiatric knowledge and techniques.

Specifically, such a proposal for psychiatric training means that the training analyst moves inside the psychiatric hospital and becomes a supervising psychotherapist as a regular staff member of the training structure. This is not to be done merely as a tactical move of convenience. The personal psychoanalysis of the resident is to be transformed into a psychodynamically sensitive process of supervision of the resident's growth as a psychiatrist. Personal analysis will be done specifically in reference to the problems the resident encounters in the execution of his functions as a developing psychiatrist. The resident, accordingly, will always have a real and immediate motivation to seek help for himself. The resident uses the supervisor as he needs to in his experiences with his own attempts to help and to know persons who have disturbances of behavior.

The most obvious change, therefore, which is involved in this proposal for an integration of all psychiatric training in one structure and in one learning process would be the shift of 300 or 400 hours which are now, in a personal psychoanalysis, devoted to supervision in learning mainly merely about the self to a supervision in learning about many other selves in relation to the self-as-therapist. By making his own individualized use of the supervisor two or three hours weekly the resident would fuse his learning about himself, his patients, his professional functions, psychodynamics, psychotherapy, and the clinical applications of general medicine all into one meaningful learning process. Such supervision should be available throughout a three-year residency, even though for part of that time the resident might be engaged in only diagnostic relations with patients or be busy with laboratory research. The psychiatric training situation, which is now split into a too-frequently loosely-structured mental hospital training in psychopathology and psychiatric treatment procedures, and a largely *in vacuo* personal psychoanalysis spatially and psychologically apart from that hospital training, would, like post-graduate training in other divisions of medicine, again be integrated.

The details of such a plan would have to be evolved out of the actual problems and possibilities presented as it functioned. As previously indicated, a great deal of knowledge about the dynamics of supervision in the helping-situation is already available. The

proposal would necessitate an additional expenditure for the supervising psychotherapist who should have no administrative power or obligation and who should devote no more than 30 hours weekly to the training structure. He should be encouraged and, perhaps, even required to maintain activity in private practice. Ideally, no more than eight training residents should be assigned to him. This would allow each resident three hours a week of supervisory consultation.

If tough-minded budget directors object to the relatively high salary necessary to attract competent supervising psychotherapists, certain practical arguments can easily be presented. In the first place, if an experimental trial proves that the psychodynamic acuity and psychotherapeutic expertness of psychiatrists trained in such an integral structure compare favorably with those of the residents trained in the present split situation, the plan would assure a general competency and adequacy in psychiatric treatment and research everywhere. Moreover, in such a supervised structure itself the increased psychotherapeutic efficacy and psychodynamic awareness in relation to the needs of patients would, alone, undoubtedly repay the cost of supervision. So, too, such a plan might very well stem the centrifugal drift of young psychiatrists from state mental hospitals about which Rosenzweig,<sup>a</sup> among others, has recently been concerned. Last but not least, such a training structure would seem to be the rational way for psychiatry to actualize, immediately, realistically, and generally, the promise of psychodynamic psychiatry.

Hilltop Orchards  
Boston Post Road  
Branford, Conn.

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# DIFFERENCES IN THE DEGREE OF SUGGESTIBILITY BETWEEN SCHIZOPHRENIC, PSYCHONEUROTIC, AND NORMAL SUBJECTS IN THE REPRODUCTION OF VISUAL FORMS\*

BY LIBERO ARCIERI

## INTRODUCTION

There has been considerable variability in the manner of defining suggestibility and in the stress which has been placed on it as a factor in psychopathology. Janet regarded suggestibility as an abnormal phenomenon and proposed it as the most fundamental stigma of the hysterical state. For Janet, it is a lack of synthesis of the personality, or a weakening of consciousness, which permits the operation of suggestion and results in the elaboration of an idea to its maximum state. Janet did not link suggestion to all classes of mental disorders. In cases of "dementia," for instance, he indicated that suggestion cannot be produced because images are no longer systematized and consequently cannot be elaborated. Janet<sup>1</sup> summarized this as follows:

"Suggestion does not belong to all mental disorders but it is a sign of a particular mental disease. There is a particular disease which unites the two essential conditions of suggestion, which are the preservation of automatism and the diminution of personal synthesis; this is the hysterical state. For my part, I have never seen a fine suggestible subject who was not clearly hysterical, and inversely I have been able to make all the experiments of suggestion on the subjects who on the other hand had decided morbid accidents."

Directly contradicting the views of Janet and the Salpêtrière school, was the approach expounded by Bernheim and other members of the Nancy school. Bernheim did not view suggestion as an abnormal phenomenon pertaining exclusively to hysterical subjects. Further, he attempted to prove that it could be induced experimentally in a majority of normal subjects both in hypnotic and waking conditions. Bernheim attributed suggestion to an increase in ideomotor excitability; impressions transmitted by sensory organs were interpreted and corrected by the brain, which in

\*This article is a part of a dissertation presented to the faculty of the department of psychology of the State University of Iowa in partial fulfillment of the requirements for the master of arts degree. The author is grateful to Dr. Charles R. Strother for his advice and assistance.

turn, effected the transformation of these ideas into movement. Bernheim<sup>2</sup> affirmed the normality of the hypnotic state by saying:

"It does not create new functions nor extraordinary phenomena; it develops those which are produced in the waking condition; because of a new psychical modality, it exaggerates the normal susceptibility to suggestion which we all possess to some extent; our psychical condition is modified so as to carry out the images and impressions evoked with greater boldness and distinctness."

The bulk of recent experimental evidence, as indicated in the work of Hull<sup>3</sup> or Eysenck,<sup>4</sup> tends to support Bernheim's contention that hypnosis and suggestibility are not pathological states.

Freud<sup>5</sup> believed that suggestibility and dissociation were only of secondary importance in the development of hysterical states; that hysteria was produced by the conversion of a disturbing idea into some physical manifestation for the purpose of ego defense. Also, he denied the effectiveness of the suggestive technique in psychotherapy, on the basis that it failed to uncover the origin, force, and significance of pathological symptoms. It is now generally accepted in modern clinical practice that suggestion can only effectuate the temporary removal of outward symptoms and cannot be relied upon as a therapeutic process.

The earliest test of suggestibility was the hypnoscope employed by Ochorowicz<sup>6</sup> in 1887. A steel magnet, bent in the form of a ring, was placed on the subject's finger. Susceptible individuals experienced a sensation of numbness and stiffness, and sometimes the finger became rigid and immovable. Ochorowicz believed this to be the result of suggestion, and he judged such subjects to be amenable to hypnotic treatment.

In America, Scripture and Seashore<sup>6</sup> designed a series of tests in which there were attempts to induce tendencies to experience subjective sensations or perceptions.

Binet (1900) developed an extensive battery of suggestibility tests chiefly concerned with sensory perceptions. One of the techniques employed was that of a "controlling idea," which involved adding progressive increments to a stimulus series for a number of trials, followed by a number of trials with a constant stimulus magnitude. A series of increasing lengths of lines was so used. The subject was to reproduce the length of each line. Where the subject indicated an increase in length in the absence of a true increase, it was scored as a suggestible response. A similar pro-

cedure was followed with progressive weights. Binet also included some tests in which there were attempts to induce suggestion through "personal influence," both negative and positive. Negative suggestion involved a contradiction of the subject's opinion in naming colors or in judging length of lines, and in noting whether the subject discarded his first judgment in favor of the subsequent one suggested by the examiner. Positive suggestion consisted of expressing an opinion before the subject had rendered his own, and estimating to what extent the subject was influenced by the examiner's opinion. Binet's suggestion through personal influence may be recognized as the same phenomenon which is described by MacDougall<sup>6</sup> as "prestige suggestion." Other tests of suggestibility similar to the Binet models, have been devised and are reported by Whipple<sup>7</sup> and Estabrooks.<sup>8</sup>

One of the more recent tests of suggestibility is known as the body-sway test. It was developed by Hull<sup>3</sup> and consists of recording postural movements. On the pretext of placing the subject in the right position, a pin with a tiny hook at its end is hitched to the collar of his coat. A black thread runs backward from this pin to a sensitive recording apparatus which, in turn, traces on smoked paper the magnitude of the subject's forward and backward postural movements. The subject is blindfolded and the suggestion that he is falling forward is repeated over and over again. This may be done directly by the experimenter, or a phonograph recording may be used. The forward postural movements which appear on the smoked paper enable a quantitative estimate of suggestibility. Suggestibility is thus operationally defined in terms of ideomotor action. Negative suggestibility, or resistance to suggestion, is indicated by the backward postural movements of the subject.

The correlation of different tests of suggestibility does not yield any conclusive evidence as to whether suggestibility is a well-defined unitary process or whether there are several independent forms. Aveling and Hargreaves<sup>9</sup> reported correlations of .48 between combined scores of two sets of tests. Tests of hand rigidity, illusion of warmth, and progressive weights were assigned numerical values and were then correlated with scores made on tests of progressive lines, hand levitation, and fidelity of report. Estabrooks<sup>8</sup> correlated a similar group of suggestion tests and obtained *r*'s ranging from—.08 to —.23. He stressed the point that no one

test may be said to measure suggestibility and that suggestion must work in a different fashion in each case. Otis<sup>8</sup> also found low correlations between individual tests and concluded that the tests were measuring different traits. The variance in these studies bears out the importance of using operational definitions of suggestibility, and differentiating many forms of readiness for response which vary with the particular procedure which is followed.

As to the factors favoring the operation of suggestibility, there have been numerous studies which have estimated the roles played by age, sex, and intelligence. Children have been shown to be more suggestible than adults, with the maximum susceptibility occurring at the age level from five to nine years. Brown, Cason and Wegrocki,<sup>9</sup> among others, have reported a greater suggestibility among girls and women than among boys and men, but the difference is slight and does not hold for all tests. Otis<sup>8</sup> reports correlations as high as .76 between intelligence and the ability to resist suggestion. However, this varies with the type of test that is employed. Where there is a large verbal element involved in the test, there is a higher correlation with intelligence; where verbal materials are not stressed, the correlation is appreciably lower. Aveling and Hargreaves used a large number of tests involving very simple instructions, and obtained a zero correlation between suggestibility and intelligence. Low correlations were also obtained by Estabrooks. Sherman<sup>10</sup> did not obtain any significant differences between the suggestibility scores of normal children and mentally defective children.

The relationship of suggestibility to schizophrenia and the neuroses has been approached from both the clinical and experimental levels. Bleuler<sup>11</sup> propounded a theory of schizophrenic negativism based on his clinical observations at Zurich. He distinguished between two forms of negativism. External negativism was the term applied to those states in which the patient did not do what was expected of him, or acted in exactly the opposite fashion from the instructions. This was usually combined with an affect of irritability or anger. Inner negativism was applied to those states in which the patient was unable to carry out his own wishes. In such instances, the patient would be seeking to express himself in one way, but would be unable to carry out the action, except by responding in the opposite fashion. The predisposing causes of negativism include what Bleuler termed ambitendency and ambi-

valency. The latter involves the arousal of two contrary feeling tones for one thought, and the former implies the setting free of a counter-tendency with every inclination that seeks expression. Bleuler described schizophrenia as being characterized by "a splitting of the psyche which hinders the proper balancing of the opposing and cooperating psychisms with the result that the most inappropriate impulse may be transferred into action just as well as the right impulse."<sup>11</sup> Some of the factors which Bleuler listed in accounting for external negativism included: (a) the autistic withdrawing of the patient into his fantasies; (b) the existence of a hurt which must be protected from contacts; (c) the misunderstanding of surroundings and their purpose; (d) the pressure of thought and other difficulties of action through which every reaction becomes painful; (e) sexuality with its ambivalent feeling tones. Negativistic action may emerge from conscious or unconscious motives; its essential feature is a turning away of the ego from reality to an autistic level.

Considering the long history of suggestibility, there has been relatively little experimentation on its use as a diagnostic sign. In 1924, L. E. Travis<sup>12</sup> compared the auditory thresholds of psychoneurotics and schizophrenics under waking conditions and during states of reverie. Each subject had a test to determine the stimulus limen for sound. He was then told to abandon himself to reverie by gazing into a crystal ball, and while in this state, sounds were applied through a receiver clamped to his head. The subject was instructed to respond by pressing a key whenever he heard a sound. All of the 22 psychoneurotic patients showed lowered thresholds during reverie, and 21 out of 24 schizophrenics had raised thresholds. Also, it was found that every person whose threshold was lowered during reverie could be hypnotized and not a single one whose threshold was raised could be hypnotized. Travis concluded that the "alteration of liminal values was due to the operation of a central set which in the psychoneurotic was characterized by a widening of the ego and a greater impressionability, in contrast to the inaccessibility and autistic withdrawing of the schizophrenic." Using a similar procedure, Dahms and Jenness<sup>13</sup> correlated auditory thresholds during reverie, and social introversion as measured by scores on the Nebraska Personality Inventory. In contrast to Travis' hypothesis, they found no consistent relationship between social introversion and suggestibility.

However, considering the difficulties involved in inventory methods, and inasmuch as only 20 subjects were used, the validity of this study is questionable.

Using Hull's body sway test, G. W. Williams,<sup>14</sup> in 1932, contrasted responses of catatonic schizophrenics, paranoid schizophrenics, and manic-depressives. Positive responses to the suggestion of falling forward were most frequent in the paranoid group which showed a percentage of 54.1, as compared with 27.7 for the manic-depressives, and 10.3 for the catatonics. The largest percentage of negative responses, i. e., moving backward in response to the suggestion of falling forward, was made by the catatonics, with a rating of 59.3 as compared with 13.9 for the manic-depressives and 0.0 for the paranoid group. This tends to support the clinical description of the catatonic as the most negativistic of all psychotic groups.

In a study of 155 schizophrenic paranoid patients, Bartlett<sup>15</sup> (1944) found that 38 per cent of the group gave positive responses to the body sway suggestion, 28 per cent gave negative responses, and 34 per cent gave no responses. Bartlett concluded that suggestibility followed the normal distribution curve among the paranoid group. He did not employ any other groups in his study, but he postulated that inasmuch as other investigators had shown that normal subjects exhibited almost no negative responses, the paranoid group should come part way between normals and other schizophrenic groups in the degree of suggestibility.

The most extensive studies on suggestibility have been those carried out by H. J. Eysenck<sup>16</sup> at the Mill Hill Emergency Hospital in London. Altogether, some 1,400 subjects, including both normals and neurotics, have been used for such studies in the past several years. On the basis of factorial analysis of eight suggestibility tests, Eysenck distinguishes between two types of suggestibility. Primary suggestibility as measured by the body-sway, arm-levitation and Chevreul pendulum tests, is viewed as a product of ideomotor action and inhibition. This is somewhat similar to the early conception of ideomotor excitability propounded by Bernheim. Secondary suggestibility, as measured by tests such as progressive weights, progressive lines, and taste, touch and smell illusions, may be looked upon as a form of gullibility. Tests of secondary suggestibility were found to correlate negatively with intelligence and showed much less functional unity than did tests of

primary suggestibility. Eysenck concluded that there is no correlation between primary and secondary suggestibility. Using 110 normals and 110 neurotic patients, Eysenck found that 63 per cent of the neurotic males and 42 per cent of the neurotic females proved suggestible to the Hull body sway test, as compared to 7 per cent of the non-neurotic males and 8 per cent of the non-neurotic females. A correlation of .66 was obtained between neuroticism and primary suggestibility. Eysenck also found that hysterics were no more susceptible to primary suggestibility than were other types of neurotics. According to Eysenck, the capacity to resist the expression of ideomotor tendencies is far less effective in the case of neurotic than in normal subjects.

The present study is concerned with differentiating the degree of suggestibility between schizophrenic, psychoneurotic and normal subjects in the reproduction of visual forms. It is believed that the procedure of setting up two antithetical tendencies in the subject—one directing him to carry through a motor act of drawing a figure exactly as perceived, and the other establishing a verbal set which will react either upon the organization of his perceptual field or the translation of the perception into a graphic representation—has the advantage over tests of suggestibility which have employed isolated sensory mediums. If this integrated sensory-motor process can be shown to be different objectively for the clinical groups in question, it may prove useful as a diagnostic instrument.

#### METHODOLOGY

##### *A. Subjects and procedure*

A total of 56 subjects was used in this study, 19 schizophrenics, 17 psychoneurotics and 20 "normals." The schizophrenic group was obtained from Norwich (Conn.) State Hospital and was made up of 10 males and nine females. The age range was from 18 to 43 with a mean age of 28.6 years. The I. Q. range was from 57 to 122 with a mean I. Q. of 87.4. The length of hospitalization varied from two weeks to 104 weeks with an average duration of 19.4. A diagnostic breakdown of the group shows that there were four of the simple type, seven hebephrenics, two catatonics, and six paranooids. The classifications were based on diagnostic staff conferences of the hospital.

The psychoneurotics were 12 females and five males. Four were from Norwich State Hospital and the remaining 13 were tested at the Psychopathic Hospital of the State University of Iowa. The age range was from 20 to 54 with a mean age of 32.5 years. The I. Q. range was from 69 to 123 with a mean I. Q. of 107.4. The length of hospitalization varied from one to eight weeks with an average duration of 2.7 weeks. The classifications adopted for the patients of the Iowa hospital were based on admission staff conferences. A breakdown of the group shows that there were eight cases of anxiety neurosis, three of hysteria, three of psychoneurosis mixed type, two cases of psychasthenia, and one case of psychoneurosis accompanied by cerebral dysrhythmia.

The normal group was made up of three psychiatric aides at Norwich State Hospital, six employees of the State University of Iowa, and 11 undergraduate students from the State University of Iowa. The total of 20 was equally divided as to sex. The age range was from 18 to 50 with a mean age of 26.4 years. The I. Q. range was from 79 to 137 with an average I. Q. of 112.7.

The apparatus used was a hand-manipulated exposure device. It consisted of a box with a black screen in front which, when raised by flipping a handle, revealed the exposure field. The drawings were inserted in a slot at the back of the box. Sixteen drawings were used, mounted on separate cards  $4\frac{7}{8} \times 6\frac{7}{8}$ ". Ten were taken from a series used by Carmichael, et al.<sup>17</sup> in an experiment on verbal set, and the remaining six were taken from an unpublished undergraduate experiment. Some minor modifications were made to facilitate the scoring of reproductions.

Each subject was seated three feet away from the exposure device, which was adjusted so that his eyes were on a level with the exposure field. Each had two experimental sessions. In the first period, the instructions were as follows: "I am going to show you some drawings. When I say, 'ready,' look carefully at this opening (pointing to exposure field), and draw the pictures exactly as you have seen them." The first drawing, a sample, was then exposed, and the subject was directed to draw it in the proper blank space. Each succeeding card was then exposed for .4 of a second and after each exposure, the subject was told, "Draw it exactly as you have seen it."

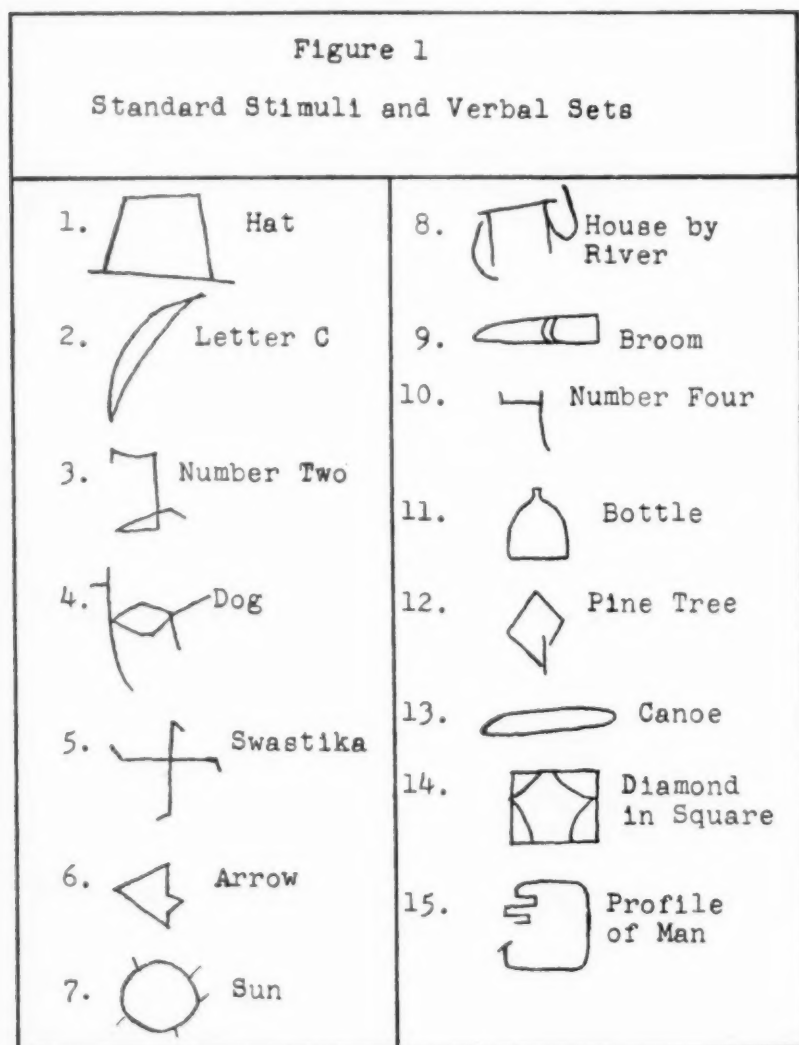
A short form Wechsler Bellevue Intelligence Test was administered to all subjects during the first session, except those on whom an intelligence measure had already been obtained.

The second session was held exactly seven days after the first. The same drawings were employed but in a different order of presentation. This order was kept standard for all subjects. The instructions were as follows: "I am going to show you some drawings. When I say, 'ready,' look carefully at this opening and draw the pictures exactly as you have seen them." After each "ready" signal, the subject was given a verbal set such as the following: "The picture you're about to see looks like a hat." Each card was exposed for .4 of a second, and after each exposure, the subject was told: "Draw it exactly as you have seen it." The standard stimuli and the accompanying verbal sets are shown in Figure 1.

Each subject in the normal group was given a Bernreuter Personality Inventory at the end of the second session.

### *B. Treatment of results*





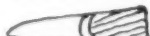


All the reproductions were scored on the basis of whether they deviated toward the verbal sets. In addition to the experimenter, two observers, both graduate students in psychology, were asked to score all the drawings, using criteria which had been set up by the experimenter. Several examples of these criteria are shown in Figure 2. The drawings made in the first session, in which no verbal set had been employed, were scored in the same manner as those made in the second session. Consequently, the first session acted as a control on any associative reactions or chance deviations in the direction of the verbal set which were not due to verbal suggestion. All drawings which deviated toward the verbal set were scored as positive and all those which did not were scored as negative. Each positive deviation was given a percentage weight of 2.22, so that if all 15 drawings of a subject were judged by all three observers as positive deviations the subject would obtain a maximum percentage score of 99.9 ( $2.22 \times 3 \times 15 = 99.9$ ). Suggestibility scores were computed for each subject by subtracting the percentage score obtained in the first session from that obtained in the second session. If the percentage score of the first session exceeded that of the second session, the suggestibility score was rated zero.



Mean suggestibility scores and standard deviations were obtained for each of the three groups. The significance of the differences between the means was computed by use of the t-test.

The reliability of the criteria was determined by computing the percentage of agreement between the observers for each item.

Rank difference correlations were worked out between suggestibility scores and intelligence quotients.

Figure 2 Illustration of Criteria for Evaluating Suggestible Deviations of Drawings	
Standard Stimulus and Verbal Set	Credit as Suggesti- ble Deviation
6.  Arrow	 a. squaring and elonga- tion of shaft   b. addition of shaft by single line
9.  Broom	 a. addition of strands or fibers   b. narrowing and elongation of handle   c. separation of handle from fiber section

The Bernreuter Personality Inventory percentiles on neuroticism (B1-N) which were available for the normal group, were correlated with suggestibility scores.

#### RESULTS AND DISCUSSION

The reliability of the scoring criteria was determined by computing the percentage of agreement of the judgments of three observers. Only unanimous judgments were taken as instances of agreement. Out of a total of 1,680 judgments, the observers dis-

agreed on 169 reproductions. This gives a coefficient of agreement of .90 and indicates that the criteria have a high degree of reliability. Considering each individual item, there are only two coefficients of agreement which are below .85. These stimulus figures are "the hat" and the "profile of a man" which obtained coefficients of .63 and .79 respectively. The principle difficulty in scoring the reproduction of the hat-stimulus figure results from the fact that the standard figure resembles a hat. Consequently, it becomes difficult to judge whether the deviations accompanying the verbal set look more like a hat than the standard stimulus itself. This stimulus figure should not be used in any subsequent administrations of the test. However, it is believed that the "profile of a man" stimulus figure should be retained, despite a rather low coefficient of agreement of the scoring criteria. The basis of the disagreements on this item stemmed from the large number of marginal responses. Thus, the "profile" is a good item in a suggestibility test, inasmuch as it elicits a wide variety of responses. Further refinement of the scoring criteria may be achieved with repeated administrations of the test.

The schizophrenic group showed the least degree of suggestibility with a mean score of 12.38 as compared to a mean score of 22.39 for the psychoneurotics and a mean score of 17.32 for the normal group. The degree of variability within all three groups was extremely high, resulting in an overlapping of the distributions of the normal and psychoneurotic groups and those of the normal and schizophrenic groups. The significance of the difference between the means of the schizophrenics and psychoneurotics, as measured by the *t*-test for small unrelated samples, was at the 5 per cent level of confidence; between the schizophrenics and normals, the differences were significant at the 20 per cent level of confidence, and between the normals and psychoneurotics, the significance of the difference was also at the 20 per cent level of confidence. Variance ratios as measured by the Fisher *F*-test were found to be not significant at the 5 per cent level of confidence, so that the comparisons by use of the *t*-test were warranted.

The schizophrenic groups showed the highest degree of variability with a coefficient of variation of 90.5. Both the highest and the lowest suggestibility scores were made by schizophrenic subjects. Zero suggestibility scores were obtained by five schizophrenic subjects, while there were no such instances among the

psychoneurotics, and only one among the normals. It should be kept in mind that negative scores were not utilized. In all cases in which the suggestibility percentage in the session *without* any verbal set exceeded the percentage in the session *with* a verbal set, the suggestibility score was rated at zero. Consequently, a direct measure of negativism is lacking. This is in contrast to the Hull body sway test which takes the degree of backward body sway as a quantitative index of negativism.

Within the schizophrenic group, the paranoids showed the highest degree of suggestibility with a mean score of 17.39 as compared with mean scores of 14.43 for the catatonies, 10.78 for the hebephrenics, and 6.65 for the simple schizophrenic type. These results are in general agreement with the findings of G. W. Williams,<sup>14</sup> except that he found the catatonies to be the least suggestible of his psychotic group. The present study included only two catatonies, one of whom obtained a suggestibility score of zero and the other a score of 28.86. Since the two scores show such a great divergence, the mean score cannot be taken as representative of the catatonic level of performance.

Considered from the theoretical standpoint, the schizophrenics who are the most withdrawn from reality should prove to be the least responsive to external stimulation and suggestion. The paranoid, being in better contact, and more sensitive to his external environment than any of the other schizophrenics, would be more amenable to suggestion. However, this is not to say that we can expect no negativism from the paranoid. Whereas the negativism of the hebephrenic, catatonic and simple schizophrenic is to be conceived of as an autistic withdrawal from reality, with a dulling and flattening of affect, the negativism of the paranoid is marked by a hypersensitivity to reality and an expression of suspicion, hostility, and resistiveness to command. It is believed that any paranoid in whom such hostility or resistiveness is aroused, may be expected to exhibit a low degree of suggestibility. Inasmuch as the six paranoids in the present study were all co-operative and did not display any apparent resistiveness toward the examiner, it is not surprising that they exhibited a moderate degree of suggestibility.

The psychoneurotic group showed a high degree of variability with a coefficient of variation of 44.8, but was more consistent in performance than either the schizophrenic or normal groups.

Among the psychoneurotics, the highest degree of suggestibility was exhibited by the mixed type with a mean score of 33.86, as compared with mean scores of 22.23 for the psychasthenia cases, 19.83 for the anxiety cases, and 14.06 for the hysterics. This is consistent with the findings of Eysenck<sup>16</sup> that hysterics are no more susceptible to suggestion than are other types of neurotics. However, the smallness of the subgroups makes it hazardous to take the scores as predictive of the level of performance of each clinical type.

From the qualitative standpoint, the performance of the psychoneurotic was marked by a strong degree of consciousness of his achievement level. The neurotic is impelled by a desire to make a favorable impression on the examiner, and is extremely sensitive to any changes in the external environment. In the task of reproducing visual forms, he is anxious to get down on paper as many as possible of the details that have been exposed. This makes him susceptible to the verbal sets which enable him to assimilate the vaguely perceived forms into more meaningful objects, facilitating his reproductions. During the second session, a large percentage of the neurotics remarked that the same pictures had been shown them the week previous. However, they were still influenced in their reproductions by the verbal sets. The neurotics frequently apologized for their performance, and also asked whether they were doing well. Such reactions were obtained from the normal group to a lesser degree but were absent in the schizophrenics.

The normal group consisted of 11 students and nine employees of the hospital and university. The students showed a higher degree of suggestibility with a mean score of 22.21 as compared with a mean score of 15.79 for the employee group. The normal group also showed a high degree of variability with a coefficient of variation of 56.2. In terms of suggestibility, they occupied a position intermediate to the psychoneurotic and schizophrenic groups. From the qualitative standpoint, however, their performance approached more closely the psychoneurotic than the schizophrenic pattern. Practically all of the normal subjects recognized the pictures in the second session as being the same as those in the first session. Two of the students also guessed that the purpose of the experiment was to see whether they were suggestible. Even with the recognition of the forms and some inkling as to the nature of the experiment, all the normals except one showed some degree of

suggestibility. The introspective reports of the subjects indicate that the verbal sets tended to facilitate the reproduction of the forms. Several of the normals were apologetic about their performance, stating that they could not draw very well, or that they had not perceived the figures very well. However, not so many of the normals as psychoneurotics exhibited such type of behavior.

The Bernreuter Personality Inventory perceptile scores on the neurotic tendencies scale (B1-N) were correlated with the suggestibility scores of the normal group. A correlation of  $-.27$  was obtained between suggestibility and neuroticism, which corroborates the findings reported by Eysenck<sup>4</sup> that suggestibility is not correlated with any of the scores obtained on the neurotic inventory type of test. Consequently, the neurotic inventory cannot be employed as a predictive index of an individual's suggestibility.

Rank order correlations between suggestibility scores and intelligence quotients were also computed. Because of the fact that the intelligence test scores of the schizophrenic group cannot be considered reliable, separate correlations were worked out for each group, none of which proved highly significant. The schizophrenics obtained a rank order correlation of  $+.18$  between intelligence and suggestibility, as compared with values of  $-.14$  for the normals and  $-.17$  for the psychoneurotics. On the basis of the low correlations with intelligence, it is postulated that the test involving the reproduction of visual forms, is one of primary rather than of secondary suggestibility. This is in accordance with Eysenck's findings that tests of secondary suggestibility show a high negative correlation with intelligence whereas tests of primary suggestibility do not correlate with intelligence.<sup>16</sup>

Mention may be made of the factors within the experimental procedure which may have acted against the operation of suggestibility. The use of a preliminary session in which the figures were exposed without any verbal set, tended to decrease the susceptibility to suggestion in the second session. Having two exposures makes for a greater stabilization of the figures and renders them more resistive to change. Further, there is created within each subject a predisposition to duplicate the graphic reproductions of the first session. Object assimilation of figures in the first session, differing from the verbal suggestions in the second session, would also reduce suggestible responses. This is illustrated by one of the schizophrenics who obtained a suggestibility score of zero. In the

first session she spontaneously mentioned the associations elicited by each figure. Coincidentally, two of the associations corresponded to the verbal sets which were to be employed in the second session. In addition, she expressed a group of associations different from those that were to be employed in the second session. These substitutions included "cigar" for "broom," "moon" for the "letter C," and "curtains in a window" in place of "diamond in a square." When the verbal sets were given in the second session, the subject persisted in her previous associations. Inasmuch as no control was available on the degree of object assimilation, the extent to which it acted as a counteracting factor to suggestibility, cannot be determined.

#### SUMMARY AND CONCLUSIONS

Nineteen schizophrenic, 17 psychoneurotic and 20 normal subjects were tested on the degree of suggestibility exhibited in reproducing visually perceived forms. Each subject attended two sessions, in the first of which the stimulus figures were presented without any verbal set, and in the second, one week later, in which the same figures were presented with an accompanying verbal set. In each session the subject was instructed to draw the figures exactly as he had perceived them. Suggestibility scores were obtained for each subject by subtracting the percentage of suggestible responses in the first session from the percentage in the second session.

The reliability of the scoring criteria was determined on the basis of the percentage of agreement of judgments of three independent observers. Coefficients of agreement were all rather high with the exception of those for two items. The stimulus figure "hat" should be omitted from the test because of its low reliability. The scoring criteria may be considered generally reliable in their present form, but further refinement should be sought by repeated sampling and evaluation of responses.

Correlations between intelligence quotients and suggestibility scores were found to be low. On the basis of this evidence, it is postulated that the present test is one of primary rather than secondary suggestibility. This is further indicated by the fact that awareness of the duplication of stimuli in the second session, as well as some insight into the nature of the experiment, did not prevent the subjects from exhibiting suggestibility. Consequently,

gullibility, which according to Eysenck's classification is synonymous with secondary suggestibility, did not seem to enter as a factor in the present test. However, the possibility that additional factors, such as prestige suggestibility, are operative, cannot be excluded. A validation of the test should be procured by correlating it with other independent measures of suggestibility.

The results of this experiment are in general agreement with previous studies, indicating that schizophrenics are the least suggestible of the types tested and that psychoneurotics show the highest degree of suggestibility. The normals occupied a position intermediate to the schizophrenics and psychoneurotics. Five of the schizophrenic subjects obtained zero suggestibility scores as compared to only one such case in the normal group and none in the psychoneurotic group. The differences between the psychoneurotics and schizophrenics proved significant at the 5 per cent level of confidence, but the differences between the normals and psychoneurotics, and between the normals and schizophrenics, were only significant at the 20 per cent level of confidence. The high degree of variability within each group makes for considerable overlapping, particularly between the normals and psychoneurotics, and between the normals and schizophrenics. Consequently, it is hazardous to use this suggestibility test for differential diagnosis. The possibility that the samples are not adequately representative of the general population groups should be tested by repeated samplings.

566 Oaktree Place  
New York 57, N. Y.

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## THE TRAUMA OF BEARING\*

BY NANDOR FODOR, LL.D.

The difficulties with which a child is delivered vary considerably, but on one point agreement is universal: Bearing a child imposes a great strain on the maternal body and sometimes results in serious injury.

Bad as the trial of the flesh is, the psychic injury accompanying it may prove even more damaging. It is the contention here that bearing a child becomes traumatic whenever the similarity between giving birth to a child and being born approaches close to the threshold of awareness.

No sexual injury is more likely to raise the ghost of our own arrival into this world than that of bearing a child; and it cannot be disputed that bearing a child is a sexual injury. It is also agreed that while time heals the worst wounds as far as consciousness is concerned, the passing of years has no meaning for the unconscious. That part of our personality does not know of oblivion, and the dynamic tensions of the memories stored up in its hidden recesses are apt to cause disturbance as soon as parallel psychic states arise in consciousness. This phenomenon is analogous to electric induction, in which a current in a closed circuit produces a similar current in a parallel circuit without a generating source. The relationship between the two momentous events; one's own birth and the bringing of a child into life, is very close, and it raises problems of considerable importance.

The number of women who become panic-stricken at the prospect of bearing a child is larger than is generally thought. The fear is often repressed; the victims know that they are not likely to die, yet they feel as if they were confronting death. It is a common experience that many women so afflicted lose their children by miscarriage or abortion. The yearning for the child is there, their conscious intention of carrying through term cannot be doubted, but an accident, shock or illness will bring about premature labor or necessitate surgical intervention. The prospective mother may not even suspect that she has set an unconscious "protective" mechanism in motion. The alibi is always excellent. Without the

\*From the forthcoming book, *The Search for the Beloved*. Hermitage Press. New York. In press.

alibi, the unconscious purpose of losing the child could not be easily accomplished.

Imperative as the breaking up of the maternal condition might be—on the organismic levels of the prospective mother's mind—the purpose is by no means always accomplished. The will to keep the child may triumph over the unconscious urge to destroy it. The writer knows of a mother who kept herself for two months on her back, after an accidental loss of the amniotic fluid, in order to save the life of the child. She won. The vitality of the fetus also plays a part in such victories. In the face of attacks directed against it, the fetus may show amazing tenacity. That tenacity is a great asset at the time of birth when the panic of the mother is likely to aggravate the difficulties of delivery.

The mother may pay a price for this panic even after her confinement. Where delivery has been dreaded, afterpains of bearing are more likely to develop than if the mother has been comparatively fearless. The menstrual flow may become excessive and painful, tears may refuse to heal, the breasts may prove troublesome, and the kidneys or the bladder may show weakness, testifying to the psychic storm through which the mother has passed and of which, in her unconscious, she is still in the throes.

Through study of the dreams of mothers before childbirth and afterward, I have reached the conclusion that the morbid fear of bearing arises from the prospective mother's identification of herself with the child in her womb. Far back in the past, the prospective mother was in the same position as her baby: She, too, was a child about to be born, and she is as frightened now as if she were about to re-live her own birth. It is as if she had lost the distinction between being a mother and an unborn child; it is as if she were giving birth to herself.

The life of many a child is lost because of this confusion in the mothers' minds. The psychological education of pregnant mothers is still wanting. Of the relationship between their own births and those of their children, they know very little. They do not even suspect that a child feels as if it were dying during a difficult labor, because no memory of their own birth-experiences survives in their consciousness. Nature saw to it that the awful memory should be locked up on the organismic levels of the mind. How then could they suspect that unconsciously they are anticipating the re-occurrence of this terrifying event?

The study of dreams which precede and follow delivery is very instructive. The expectation, and the actual delivery, of the child tend to mobilize falling-fears, nightmares of water, fire and suffocation, and may even produce symptoms of claustrophobia. The dilatation of the uterine passage in delivery is often reflected in dreams in which large and gaping cavities open up in the body, sometimes in the nipples or even in the baby's mouth. In one dream of which the writer knows, the opened nipple assumed the semblance of the vagina.

A friend of mine who gave dry birth to a son had a recurrent dream for many years in which her son was always under water, drowning. The dream filled her with dreadful foreboding as, following the usual pattern, she automatically projected it into the future and placed a prophetic construction on it. One day she herself conceived the thought that an early loss of the amniotic fluid might have originated the dream. She recalled how fearful she was that her child would be born crippled or dead. Suddenly she realized that she had kept this fear alive and played it again and again as one plays a phonograph record. From the day of this realization, the recurrent nightmares stopped.

Nightmares of fleeing from pursuit (to escape the ordeal of child-birth) may alternate with erotic dreams in which a new-born son figures as a lover. Such dreams indicate that the child is in the same relationship to the genitalia in the process of birth as the male organ is in intercourse. In slang, the male organ is often called the little man, the child. This slang may help one to understand how the birth of a child can liberate repressed fantasies of intercourse or rape. No young mother should be ashamed of such dreams. By repressing them, she may sow the seeds of future trouble. By understanding and frankly discussing them, she may free herself from their recurrence.

The writer's experience is that any event which is capable of mobilizing the memory of birth, intensifies the trauma of one's own birth. The trauma of bearing is particularly apt to merge into the mother's birth trauma. On a patient's understanding the part which one's own birth plays in childbearing, an almost miraculous relief may be obtained from complaints resulting from a difficult delivery. Without such release, the neurotic condition—now a double-barrelled affair—will persist unchanged. Successive deliveries may be easier, but psychically still very trying. As the

years pass, more and more of the pressure will be converted into symptoms necessitating internal operations or causing some other physical debility.

A mother dreams that she is in a bear cage and is torn to shreds by a polar bear. She wakes in terror. She cannot imagine what could have caused such a nightmare. Yet the dream is almost self-explanatory. Polar suggests ice, frigidity, fear. "Bear" stands for bearing, giving birth and the fear of one's own birth. The cage is an excellent symbol for confinement and pressure from which there is no escape.

This dreamer, well past the childbearing age, has been frigid all her life and has suffered, for many years, from extremely high blood pressure. The birth of her first child was a very difficult affair, an instrumental delivery resulting in tears. Further, the child was unwanted, and the mother had to go through a good deal of hardship on its account.

The dream suggested that much light could be found as to the origin of the dreamer's chronic hypertension through an investigation of the trauma of her bearing and its foundation, the trauma of her own birth.

Proper psychological education as a preventive maternal therapy could bestow immense benefit in health on the female population of the nation.

#### BEARING AND ABORTION

Moral considerations might be as important as physical ones in producing a trauma of bearing. The stigma of having an illegitimate child, or conflict with the criminal code because of an abortion prior to bearing, obviously increases the psychic burden. Guilt reactions appear in dreams even when the loss of the child was unintentional or was demanded for medical reasons. The moral score is not settled by the harrowing nature of illegitimate operations. How soon the unconscious tribunal of justice, the super-ego of Freudian psychology, converts the guilt into sickness depends on the sensitivity of the conscience.

Most often there is an attempt to put the dead child back into the uterus in the symbolic shape of a cyst or tumor in the ovaries, the uterus or the breast, or by a stone in the bladder, gall bladder or kidney. These are primitive substitutes but who knows

whether, other factors being favorable, a malignant growth or a cancerous development may not also arise from excessive psychic pressure?

The extent of self-destructive measures, by successive operations—to which miscarriage and abortion guilt may lead—knows of almost no limit. Life is inexorable in its demands for the perpetuation of the species. It seems almost as if the woman who loses a child through her own fault sins against the race and as if the retribution which follows is an archaic, evolutionary safeguard. Yet, too much importance should not be attached to this appearance in view of the relative ease with which such guilt can be resolved. Basically, the guilt seems to originate from the confusion with which the trauma of one's own birth infuses the situation.

The reason why an understanding of this trauma produces relief and an almost instantaneous change in neurotic behavior is that it lifts from the psyche the burden of personal responsibility. It is a marvelous feeling to realize that it is not our conscience that troubles us for reason of past transgression but that we are victims of a universal calamity. Guilt ceases to be guilt when it is universal. We cannot get beyond the pale if everybody else is there. It is not our fault that we were born. However, this high road out of neurosis is destroyed when a woman's self-inflicted abortion merges with the trauma of birth. It not only raises the dynamic tension of birth but invests it with guilt; hence the intensity of punitive reactions, and the persistence of the demand for self-destruction on a double score.

Some dreams so openly reveal the psychic pressure of abortion that to tell them amounts to a public confession. Here is an illustration:

"I was lying on my back, naked, with my legs apart in the shape of a V. A shadowy person seemed to be repeating whatever I did. I felt her presence but I could not see her. I had a hatchet in my hand and was hacking away at something that was between my legs. It was not part of me. In doing so I scratched my thigh, and I could see a long, thin, red line. Whoever the person was, she said: 'You cut your leg.' I said: 'That is nothing, a little iodine will fix it'—and I went on hacking. Then I had a baby in my arms, and the baby's head was cleft from the forehead to the back. I could see the pulse beating under the cerebral membrane."

No explanation is necessary, except that the shadowy person is the dreamer's conscience. Representing it as a split-off part of her personality explains why she could be so unconcerned regarding the injury which she had inflicted on herself by abortion.

Curiously, she was not quite aware of the meaning of the dream. One may believe she deliberately shut her eyes to the implications. The airing of her guilt had a very salutary effect. A few days later she dreamed of a court scene, which was the dramatization of her self-trial for abortion. A sequel, leading to another important revelation, came in the following dream:

"I went to the bottom of our garden at home and crept into a thicket of wild roses. Then I saw that the rose bushes were suspended in the air, one on each side of me, a tremendous growth of roots hanging from them as if they had been violently torn from the earth. As I was standing there, I saw a meat safe to the left of me, the old-fashioned wire affair which we hung on trees in Australia to let the wind blow through it and keep the meat cool. A lot of rotten meat was in the safe. The bottom of it was torn away and the whole safe was hanging in the air."

On awakening, the patient's immediate association was to a butcher bird which she had once seen in their garden sitting on the bough from which the safe was suspended. The butcher bird, she explained, is a beautiful but very cruel bird; it kills other little birds. The wild roses reminded her of a song in which a boy wants to pluck roses and they threaten to prick him.

These two associations explain the dream fantasy. A child may well be called a rose. The torn-up roots suggest the violence of the separation from Mother Earth or the maternal body, also alluding to the strength of unconscious ties. The meat safe is the womb. The bottom which dropped out hints at the opening of the cervix. The fact that she is not getting hurt by the thorns when creeping into the thicket indicates that her burden of guilt is easing.

However, so far the patient only confessed to one abortion. The dream hints at two—by the two rose bushes. Was there one which she only suspected to be an abortion but of which she was not quite certain?

"There may have been another," she stated, "a miscarriage. I had a queer menstruation once, previous to my abortion. A lot

of white fluid came out and I had fever. I suspected I might have been pregnant and that, for some reason, the pregnancy was naturally broken up."

This fits in well with the intimation of the dream. If we accept the interpretation that the two wild rose bushes refer to two illegitimate children, we have an impressive indication that abortion guilt may arise, even though the conscious is unaware of the loss of a child. Apparently then, the super-ego, from its residence in the unconscious, may sit in judgment over the organism itself for failing to fulfill its destined role.

A more simple intimation of unsuspected miscarriage is presented in this dream of a 17-year-old girl:

"I have a tiny baby on my open left hand. Its head breaks off and I feel so sorry. I am trying to glue it back. Somebody says: 'I have worked eight months for this.'"

In association with eight months, the dreamer said that her favorite uncle's wife expected a baby in a month's time. This suggests that the numbers in the dream should be interpreted reversed, and that the *tiny* child on her open left hand is one month old. Which raises the suspicion that the dream speaks of miscarriage.

As soon as this interpretation was presented, the dreamer confessed that her last menstruation was unusually heavy. She had no idea that she had been pregnant, but admitted that she could have been. The dream indicates that she was, and that something within her was grieved over the breaking up of the condition.

Another eloquent illustration of the unfailing record kept by the organism as regards reproductive activities might be seen in this statement of another patient:

"I cannot eat beets, red beets. The other night I dreamed of walking in a field with my husband. I saw two horrible, large purple beets and I had to scrape them."

The scraping suggests curettage. The two beets would indicate two abortions—with her husband's knowledge, as she is walking with him.

The patient admitted she had had one abortion. As to the second, she was not certain. Her menstruation was delayed, and she took injections to bring it back. It is quite possible that her unconscious looked upon these injections as a form of curettage. Whether she was actually pregnant or not, the very safeguard in-

volved a potential murder. She had injections a third time also, but subsequently came to the conclusion that there was no need for them. The dream bears this out by omitting a third possibility of pregnancy.

"I used to dream a lot about pocket books, open and closed. There was a black one which I had to get through a window. It was hard to get it. I had to scratch it off with my hand when I reached for it."

This is another dream of curettage by the same woman. The black pocket book is her womb. The window is the vaginal entrance. The scratching stands for scraping.

#### BLOOD GUILT AND BEARING

There is another psychic situation in which birth can be infused with guilt, with the result, in retrospect, that the dynamic tension of the trauma of birth is increased. It is provided by unthinking mothers who tell their children of the terrible injuries which their arrivals in this world inflicted on them. Children resent being saddled with responsibility for their births. Their verbal reaction is: "I did not ask to be born." They refuse to shoulder the guilt which is imputed by their mother's sado-masochistic statements. Nevertheless, the reproach has a sting; and, once it is voiced, unconscious reactions may follow. If detected early in the dream life of the patient, this putative guilt of having shed the mother's blood in birth is not difficult to dissipate, but as long as such silly guilt-feeling remains undischarged, it may add significant content to the neurotic complex.

The truth is that the shedding of blood is inevitable in birth. The mother suffers from hemorrhage, the child loses blood in the cutting of the umbilical cord. There is dream evidence that in some cases the olfactory system of the child begins to function sufficiently early to register a shock caused by the smell of blood. The very suggestion of such possibility should make us wonder as to how much harm may be done to the child by the sight of the mother's carelessly displayed menstrual pads or unflushed blood in the toilet bowl. Shocking misconceptions may arise in the unconscious. Illness of the mother may cause a child to brood as to whether it was giving birth that made her ill. The child may not be able to cope with the resultant mental burden. Nightmares of injuring the mother in birth are not uncommon. Women may be-

come frigid or may dread pregnancy and childbirth as an impending retribution for a non-existent crime. The law of Moses, which is the law of the unconscious, demands that they should be punished in the same way in which they sinned. In giving birth to children they should be hurt as their mothers were. Hence the depression. If no pregnancy occurs, they still can be hurt in the genitalia, because they are the loci where the mothers suffered their injuries. So, by a process of translation from the maternal body, sexual frigidity may develop.

A woman whose Fallopian tubes were tied after an operation becomes alarmed over the absence of her menstruation. Suppose the doctor was wrong and she can and will have a baby? She is frigid, has no conception of what an orgasm is, but she knows that frigidity is not a bar to becoming pregnant. One night she dreams of passing along a dark street in a floating position, lying on her back. She feels very upset about proceeding in this manner and pulls herself into an upright position by holding to a fence; she then walks and reaches a house on a sharp hill. The window has no glass; it is just an opening, and many people are standing in front looking in. There is light enough to see that they are watching a woman who is going to have a baby. It is a disturbing sight.

The dreamer then goes into the house to ask the people the way back to New York, as she feels lost. All this time the woman, who is to give birth, is walking around. Finally, they make her lie down. The dreamer thinks that now she will be able to get away. Just then the woman's husband comes in, throws the dreamer on the bed and tries to rape her. She wakes, screaming for help.

The floating position depicts her as an unborn child in the amniotic waters. She is lost in the maternal situation. Hence the child to whom the woman in the house is about to give birth is the dreamer herself. The restlessness which the mother exhibits in walking is her own restlessness, and is due to the pressure of the memories of her arrival in this world. The attempted rape establishes an equation between birth and the forcing of the genital passage in intercourse. It exemplifies the manner in which the trauma of her birth has been translated to her own genitalia. She had forced her mother's genital passage in birth and—mentally befogged over the origin of the fear which this event had left on her organismic mind—she set out to protect herself against the recurrence of this ordeal by resisting the penetration of her own

genitalia. Frigidity and pregnancy fears served this end very well; unhappily for her, the protective mechanism resulted in a crippling of her emotional life until psychoanalysis rendered her free.

The two principal ways by which the psyche attempts, in its own unaided way, to dispose of the pressure of the trauma of birth are: (1) projection into the future on death, (2) displacement on something in the present outside ourselves. If we can fear something distant in time, or something avoidable, there is no immediate threat to our safety. Death may be far away; high places, tunnels, caves and compression in crowds may be avoided; water we can keep away from; bridges we need not always cross. A variation of displacement is the transposition from below to above or further below. For the unconscious, all bodily orifices equate with each other. A fourth way of disposing of the trauma of birth is translation, as illustrated by the preceding case. In its most common form a woman's own genitalia are substituted for the mother's, and the trauma of birth is converted into frigidity, pregnancy anxieties and a morbid fear of bearing children. In other instances, the translation takes place in accordance with ideas of anal birth and produces chronic constipation. Of the organs other than the patient's own uterus which can substitute for the mother's womb, the stomach should be singled out because we feed our infants with stories that the child is carried in the mother's "tummy." In the course of conversion, the trauma of birth may manifest itself in chronic attacks of nausea and other digestive disturbances. The all-around result may be a morbid expectation of operations, or inability to contemplate marriage, or fainting spells, or epileptic seizures.

The following case should be of unusual interest because the trauma of bearing, activated by an illegal operation, was converted into a painful growth, a verruca on the patient's right foot just under the arch. From the viewpoint of the trauma of bearing, this was a case of transposition from above (the genitalia) to below (the foot). From the viewpoint of its remoter determinant, the trauma of the patient's own birth, it was a case of translation. The growth must have taken considerable time to develop but the patient only began to feel pains at the time of the beginning of her analysis. She thought she had a corn, with a very deep root. Eventually, she was delivered from her discom-

fort and pain through the services of a chiropodist, but not until some curious associations and dream material illuminated the psychological background of her complaint.

The first revelation came in recalling that for six months after her arrival from Germany in the United States she was very reluctant to pronounce the word foot. The reason was the similarity of the sound to "*Fuß*," an extremely vulgar German term for the vulva. The association permitted the assumption that the foot had been invested with a genital significance. The position of the verruca right under the arch now appeared in a new light. The arch suggested an equation with the pubic arch, and so the question arose whether the growth could have represented a child lost by abortion or miscarriage. The answer was that, indeed, at the age of 22 the patient had a curettage performed on her after three months of pregnancy. The revelation was made with considerable reluctance. Two weeks later, she had a dream in which the curettage and the verruca were linked in a fascinating manner:

"There was a new-born baby and I put it very secretly into a zipper bag. I did not want anybody to know about it.

"Then I was in the woods and moss was on the ground. I shoved it aside with the instep of my right foot, and it started to glow like coal and burned my shoe. It swelled up, too, and the moss was a small spot of green on top of the glowing thing.

"Then I find a zipper bag and take it home. There is a dead baby in it. I put it behind the stove and am trying to figure out the best way of disposing of the body without anybody knowing. Perhaps I could put it in the incinerator or throw it from the Empire State Building. Then I open the bag. It is full of water, and the dead baby is in it."

The zipper bag figures twice in the dream. It is a symbol for the womb. Putting the baby secretly into the bag suggests conception, while finding it dead in the waters indicates the opening of the womb for curetting and the destruction of the child in the amniotic waters. No doubt was left as to the correctness of this last interpretation when the patient recalled in connection with the stove that the doctor had put the scrapings of her uterus into the fire in the stove—which made a horrible impression on her.

The curettage took place in Germany, and there was no incinerator in the patient's house there. Therefore, the incinerator, as well as the Empire State Building, infuses into the dream the cur-

rent level of experience. Incineration meaning the disposal of waste, its introduction points to the purpose of the dream—which is to deliver the patient from her abortion guilt. The Empire State Building is a confirmatory reference. Dropping a baby is a common expression for miscarriage. Dropping from the “empire state” has a certain reference to the fetal dominion. The patient’s only association with the building was that it was always empty. (This was in the days when office space did not yet command a rental premium.) We may say that the emptiness of her womb produced by the dropping of the child was the foundation of her bearing-trauma.

All this is almost self-evident, but only part of the story. The really startling element centers on the moss. The normal way to scrape it off the ground would be by using the toe of the shoe. In the dream, the patient does it the hard way, with the instep of her right foot, calling attention to the very spot where a growth was in her flesh. Moreover, her own name began with the letters “MOS.” As the moss is a very slight growth on the body of Mother Earth, the scraping is a clear allusion to curettage. The fire-like, glowing coal and the burning of her shoe are excellent references to the injury inflicted by the curettage on her body and on her mind (coals of conscience). Any further doubt as to the representation of pregnancy is dispelled when a ball-shaped swelling is formed with the green moss on top.

It is unusual to find such a clear-cut example of transposition and conversion of abortion guilt into an actual growth. While the revelation of the psychological mechanism by no means disposed of the need of operative intervention, it prevented the continuation of the game of hide and seek which this patient’s guilt complex had imposed on her mind and body before it was bared to consciousness. Had it not been bared, I am convinced that in due time another growth, somewhere else in her body, would have continued the self-destructive trend which the operation for the verruca had shaped—which raises the speculative query as to the percentage of operations women might avoid by a better knowledge of the content of their unconscious.

Park Sheraton Hotel  
870 Seventh Avenue  
New York 19, N. Y.

## ARMCHAIR PSYCHIATRY\*

BY G. H. STEVENSON, M. D.

The title of this paper was not chosen to obscure the material which is to be discussed, nor will anybody be urged to join a society for the promotion of a new division of psychiatry. Most of us are members of too many organizations now. In the field of psychiatry we have at least a dozen subdivisions—clinical psychiatry, child psychiatry, military psychiatry, administrative psychiatry, forensic psychiatry, orthopsychiatry, preventive psychiatry, neuropsychiatry, to mention only a few of the larger groups. If there were an organization of armchair psychiatry, it would have no officers, no constitution and no meetings, the natural indolence of persons who are armchair psychiatrists being so great that they would lack the energy or desire to form themselves into an organic structure.

And yet there are armchair psychiatrists, even as there have always been armchair philosophers, from whose discipline the term is borrowed. And although armchair philosophers are not highly regarded today, nevertheless, they have a great and honorable tradition, from Plato and Aristotle to Dewey and Hutchins.

It would be difficult for clinical psychiatrists to be preponderantly of the armchair type, because there are so many sick people demanding active help. But perhaps all of us should set aside a little time each day for armchair reveries. Unexpectedly interesting ideas in connection with our work or with other aspects of our lives might well up from the depths of the unconscious, or be synthesized by other psychological processes. Newton is said to have been reclining under an apple tree, if not actually sitting in an armchair under it, when the idea of gravity came to him. And I might add that the late Sir Frederick Banting sat in the armchair in his office for 38 days, waiting for patients who did not come—and while he was reading and thinking there about diabetes, the idea of insulin was evolved. His armchair produced the idea, his laboratory confirmed it.

This preamble in defense of armchair psychiatry may lead one to suspect that this is my favorite field of psychiatry. Indeed,

\*Delivered at the annual dinner of the New York Society for Clinical Psychiatry, New York, N. Y., January 13, 1949.

there would be no hope of concealing it. Having been superintendent of a public mental hospital for more than 20 years, how could I be otherwise? Yet I insist it is the chief duty of a mental hospital administrator to keep his clinical interests and responsibilities as the first and most important of his duties. His clinical interests should be kept pure and unspotted from the world of hog raising, plumbing or tomato growing. One of the most shocking sights in psychiatry is that of the psychiatrist, who having achieved the superintendency of a mental hospital, replaces his clinical interest by pride in his prize Holsteins, the output of his cannery or the efficiency of his laundry. Important as these aspects of a mental hospital may be, the responsibility for them can well be delegated to non-psychiatric assistants. The patient, the sick human, should always be the focus of the interest, ability and energy of the good psychiatrist in a hospital superintendency.

It has been my privilege for the past 30 years to work in public mental hospitals, and for the past 15 years to have held concurrently the chair of psychiatry at the University of Western Ontario. (I almost wrote the armchair of psychiatry.) Although in this latter position I have had to keep abreast of the development of psychosomatic medicine, general hospital psychiatry and psychiatry in private practice, nevertheless, I have had little opportunity to spend time in these developments, as most of my time and thought must be given to the patients of a public mental hospital, the Ontario Hospital at London. To some, this may appear unfortunate and few readers would wish to exchange places with me. Yet I can truthfully say there has never been a day of those 30 years that I have not enjoyed my work, and I hope that those 30 years have not been lived and worked in vain.

But the purpose of this essay is not to reminisce on 30 years of what some may regard as a misspent life, but rather to discuss some of the clinical problems in psychiatry which are currently exciting my interest, as I see them from an armchair in a mental hospital, and, which I trust are also of interest to my colleagues.

The first point I should like to mention concerns the recurrence of affective mental illness in many persons who require repeated admissions to our mental hospitals. From the cushioned depths of my armchair I have ruminated on this matter and have sought to develop some ideas that might lead to a lowering of the recurrence rate. All of us know how distressing it is to have certain

patients recover from a severe mental illness only to relapse six months, a year, or two years later—and to keep on recovering and relapsing. Of all the patients we send out from our hospitals in various stages of recovery, hoping for their permanent rehabilitation, too many return for further treatment because of relapses or recurrences. Although many of our mental hospitals in the United States and Canada do a fine job of therapy while the patient is actually in the hospital, some of us do too little to aid the patient in his social rehabilitation or to help him remain well. In view of a somewhat high readmission rate, we would seem to be neglecting an important duty to the patient. Granted that many mental hospitals have one or more social workers for aftercare of recovered patients, nevertheless, our vision needs to be enlarged to a fully developed aftercare department. For the average-sized mental hospital, 20 or more people, psychiatrists, psychologists, public health nurses and social workers should be constantly in the field, taking patients from the hospital to their homes, staying with them as long as may be helpful, and returning to them as frequently as assistance may be indicated. At the Ontario Hospital, we have as yet been able to obtain only a fraction of the number of aftercare workers needed to help keep recovered patients well.

However, we have developed a useful technique to aid progress toward this objective, which we call "prophylactic electroshock." This technique and its results were described in a paper presented to the American Psychiatric Association last May in Washington by Dr. J. J. Geoghegan and myself, and published in the January 1949 issue of the *American Journal of Psychiatry*. The idea came to me some five or six years ago from the well-upholstered depths of my armchair. I reasoned that if electric-convulsive therapy could clear up most affective disorders fairly promptly, restoring emotional equilibrium, then perhaps periodic electric convulsions after recovery might clear up accumulating emotional tensions before they could become clinically visible as another affective illness. To test the theory, we listed a group of patients who had had two or more illnesses in the preceding five-year period, and who had recovered from their most recent illness. We requested them to return to the hospital once each month for a single electric convulsion. Thirteen of the group accepted our offer. Our report last May, covering a three-year period, showed that when

such a program was continued faithfully, no manic-depressive patients had relapsed. I am now able to say, at the end of four years of prophylactic electric shock, that there are still no recurrences in this group. As a control group, we had 11 patients who were also offered this program, but who declined it. Within the same three years, all 11 of the control group had had one or more readmissions. The two groups were as similar as two groups can be; and the remarkably contrasting results lead us to think that the old curse of recurring attacks of manic-depressive illness may soon be a thing of the past, if the patient is willing to co-operate in some such plan. We hope to extend the interval between the prophylactic convulsions, and some of those who have co-operated faithfully are now on a two-month basis instead of a monthly basis.

To some, this may appear to be a questionable method of preventing recurrences. It is certainly not without its hazards and its unpleasant features. The only other known method is to be alert to the reappearance of early symptoms and to institute shock therapy vigorously as soon as symptoms appear. This method is theoretically desirable but is practicable in only a small percentage of the cases. As an example, and we have only one, I would cite an elderly woman who had had clear-cut manic attacks nearly every year for 25 years, each attack lasting several months. We had never been able to abort oncoming attacks by conservative methods, and because of her advanced years and general frailty we had not given her electric convulsive therapy. However, in the autumn of 1944, as another manic attack began by increased "busyness," quarrelsomeness and talkativeness we decided to try to break it up by intensive electric convulsive therapy. To our surprise, the attack terminated in four days. She remains in the hospital, however, of her choice, having no relatives to whom she can go, and whenever we see the prodromal signs of a new manic attack we give several electric treatments with immediate results. She has had no real attacks of manic illness during these last four years. But this method can be employed only because she remains in hospital under constant observation. For most recovered patients who have had two attacks in a five-year period, and who are now in their homes, we believe that the technique we call "prophylactic electroshock" is feasible and reasonable until some better method of preventing recurrences has been found. Our experi-

ence has convinced us that recurrences in manic-depressive illness can commonly be averted by the means here outlined.

Prefrontal leucotomy might also be thought of as a possible means of preventing recurrences. But while psychosurgery might be indicated in persons who are more or less constantly ill and have failed to respond to all other therapies, no one would suggest that it should be applied to the person who has an affective illness only every two or three years. Theoretically, there is always the possibility that some manic-depressive recurrences might be averted by intensive reconstructive psychotherapy. I am not aware of any evidence that proves this can be done. It is an objective greatly to be desired, but until recurrences can be prevented by psychotherapy, we think that prophylactic electric shock is at present our best hope.

Like all armchair psychiatrists, I have often ruminated on the difference between the manic-depressive illnesses and the schizophrenic, as well as on their resemblance, and on their atypical and combined forms. One is constantly confronted by the problem of attempting to evaluate etiologic factors in any given patient, especially inherited factors. Certainly a family history of mental illness or other psychopathic state is common in patients afflicted by these conditions. But it is surely naïve to assume that merely because a parent and child have both been mentally ill, the child has therefore inherited the mental illness. We no longer make the equally naïve assumption that a tuberculous child inherits his tuberculosis from contaminated genes in the germ plasm of a parent. But it took us a long time to correct our error as to the inheritance of tuberculosis. It is taking us even longer to correct it in the field of the biogenic mental illnesses. While we cannot ignore or deny the probability of constitutionally inherited patterns, this is by no means the same thing as saying that schizophrenia is an inherited disease. The schizoid pattern may be inherited (and surely all of us have some schizoid features) but it takes years of faulty training, faulty conditioning and faulty mental hygiene to produce from the schizoid pattern the disease we call schizophrenia. As I observe from my armchair this endless procession of mentally sick persons, I notice one feature about the pattern that, so far as I know, has not been emphasized in the literature. It may not be important, but again, it may be. It is this: A manic-depressive parent may have a mentally ill child, who will

be either manic-depressive or schizophrenic. But if a schizophrenic parent has a mentally ill child, the child is never a manic-depressive.

Kraepelin makes the only reference to this relationship which I have been able to locate. In discussing the effect of heredity in the affective disorders he states: "Dementia præcox does not seem to play any part worth mentioning in the hereditary series. . . ." Furthermore he quotes Rüdin as follows: "Manic-depressive parents not at all infrequently have children with dementia præcox, while the reverse case belongs to the rare exceptions."

Why should a schizophrenic parent never have manic-depressive offspring? I don't know, being only an armchair psychiatrist. But I have never seen it happen, nor have any of my associates been able to show me such a relationship in their patients. This observation has a corollary which I believe to be equally true, that is, that a manic-depressive patient may become schizophrenic, but a schizophrenic never becomes manic-depressive. Schizophrenia being so much more malignant than manic-depressive illness, perhaps this fact of inheritance may be merely a psychiatric way of expressing the generally-accepted belief that it is easier to fall down a cliff than it is to fall up a cliff, although this may not be a very scientific way of expressing the idea and certainly is not so concise as the formula for atomic energy. As a footnote to this part of my presentation you might be interested to know that in the preparation of our clinical histories we omit altogether the traditional opening of the family history with its emphasis on the alcoholism of the grandfather, the suicide of Aunt Mary, and the epilepsy of Cousin John. Such information can only mislead the young psychiatrist into the belief that mental troubles are inherited, and lead him away from really significant family history, the history of the family circle in which the patient was born, raised and damaged.

The third point I should like to make has no practical value, such as I hope prophylactic electric shock may have, nor has it appreciable theoretic value, such as this law of inheritance may have. But perhaps it has some relationship to the art of psychiatry, the art of integrating psychiatry and general medicine. Whether we like or dislike the term psychosomatic medicine, we realize that the concept it expresses has greatly lessened the gap between physical medicine and mental medicine. We, as psychiatrists, are

learning and demonstrating that psychiatry is not a subdivision of medicine but is an aspect or a part of the whole field of medicine. Internists and surgeons and general practitioners are learning that they cannot practise general medicine, or their specialties broadly, if they neglect the psychic and social factors in disease and health. We know that we must study the whole man in his psychosomatic-social interrelationships. This finding of a common ground means, too, that we should speak a common language, basic English (or basic American, if you prefer). Perhaps psychiatrists can lead the way by stating frankly that there are no mental diseases, and, therefore, there is no classification of mental diseases to memorize and get confused about, and that we can forget there ever were such concepts as psychoses and neuroses. Some psychiatrists might say this is all nonsense, but as I proved all these points to my own satisfaction while sitting in my comfortable armchair, without recourse to the laboratory or clinical experiment, I am forced to believe I am stating the truth. The point, of course, is that people become ill, and that the symptoms of their illness may be manifest in one or more ways, such as pain, intestinal disturbance, skin rashes, fever—and also psychic disturbance. But all of us know that symptoms do not constitute the disease, and mental symptoms are merely symptoms, not the disease. Consequently, in my thinking, I have discarded the old psychiatric term psychosis and use the much better understood medical term “delirium,” as its equivalent. When we remind ourselves that the general medical man has always accepted responsibility for sick people who were delirious, but evaded sick people who were psychotic, we see what can be gained for the benefit of the profession and of sick people by making obsolete the word “psychosis.” In Shakespeare’s time the word was “madness,” in the eighteenth century it was “lunacy,” in the nineteenth it was “insanity,” in the twentieth century it became “psychosis,” and helped to divorce psychiatry from general medicine. The use of the word “delirium” ought to help to reunite us on a common medical ground.

Of course, there are always some people who insist that the dictionary be the authority for the meaning of a word and they may find some distinction there between psychosis and delirium. But while recourse to the dictionary is a useful procedure to learn the origin of words, their compounds, their synonyms and their anto-

nyms, the free man will refuse to be enslaved by a dictionary. If the meanings as written in the dictionaries do not satisfy modern needs, by all means let us modernize the dictionaries rather than archaize ourselves. Dictionaries should serve us, not master us. Certainly, if we accept only the meanings justified by the etymological roots, the word "psychosis" could never mean an *abnormal* mental state, nor would the word "neurosis" be suitable for an emotional disturbance.

The older practitioners identified the low, muttering delirium of typhoid fever, and readily distinguished it from the delirium of pneumonia and delirium tremens. In addition to these types of delirium, should we not also speak of affective delirium, schizophrenic delirium and arteriosclerotic delirium, always recognizing the fact that the delirium is not the disease, but only the mental symptomatology of disease?

I am much interested to learn from Hinsie and Shatzky's *Psychiatric Dictionary* that the term "delirium" was at one time equated with serious mental derangement. It is regrettable that this equation was discarded in American psychiatry (it is still a valid equation in French psychiatry) and I would urge consideration of a return to the solid, meaningful word "delirium" in place of the etymologically inaccurate and non-medical word "psychosis."

And if we are to replace "psychosis" by "delirium," shall we not also discard neurosis and psychoneurosis? What shall we use in place of them? Surely not such verbal atrocities as "nervous breakdown" or even "nervousness." If there is an emotional disturbance, why not call it that, so that the patient may recognize his problem for what it is?

A common medical language ought to help make a common ground for a partnership with our medical colleagues in other fields. If we will discard psychiatric terms for medical terms which are understood by all physicians, we will have taken a progressive step in the interests of both the patient and the profession. I would suggest that as psychiatrists we should not insist that all sick people with mental symptoms be necessarily our responsibility and ours alone, but rather that we should seek to be especially qualified as psychopathologists and psychotherapists. In these fields we can develop research knowledge and treatment skills and thus make our contribution to the welfare of sick people.

General medicine must include psychiatry, and psychiatry has no life apart from general medicine.

The fourth and last problem which I should like to touch on may have its practical application within the field of group therapy, a popular subject today, even though various aspects of it emerge from the daydreams of the armchair psychiatrist. I am referring to what I like to call international psychiatry, which of course deals with the psychopathology and psychotherapy of national groups of people in their international relationships.

Many psychiatrists may hold the opinion that we, as psychiatrists, have no right to enter the international field, or may deny that clinical psychiatry has any direct relationship to international frictions. But if a psychiatrist has the right, yes, the responsibility, to be concerned with the mental health of one person, has he not much more the right and responsibility to be concerned with the mental health of groups of people, even national groups of people? If medical men should see any other plague approaching, a plague that would take the lives of millions, that would damage the health of millions more, and if the same medical men did nothing to try to avert such a plague, would they not be remiss in their plain duty?

If we psychiatrists, understanding the causes and the effects of disturbed emotions, understanding the effects of inferiority feelings, of rationalization and projection, of anxiety and fear and greed, do nothing to prevent World War III by our scientific knowledge, will we not have failed in one of our great public health functions? If we fail to make clear to the people generally the unsublimated aggressiveness and other psychopathic features so commonly seen in people who aspire to national leadership (those fatally magnetic qualities that lead so many people to their doom), and if we do not urge the development of ways and means to prevent psychopathic persons from attaining that leadership, then are we not aiding the forces of personality destruction, the world wars which have decimated our peoples? Wars and atom bombs are the psychosurgery of the nations. The recent war relieved the mass paranoia of Germany but left that once great nation a barely vegetating organism, and the disastrous effects of war have been felt by the victors nearly as much as by the vanquished. Is there not a place for group psychotherapy on a large

scale, and the application of the principles of preventive psychiatry, so that the common people of all countries may be justified in mutual confidence in one another and may develop their personalities in a mentally healthful way?

From time to time after World War I, individual psychiatrists drew attention to the psychopathology which so often underlies international difficulties; but the first real challenge from psychiatrists to all other psychiatrists and to national leaders to recognize it and do something about it came from the Netherlands Medical Society in 1935. The challenge in the form of a manifesto was sponsored by outstanding psychiatrists in many countries.

In my presidential address to the American Psychiatric Association in 1941, "The Psychiatric Public Health Aspects of War," I reviewed these historical developments and summarized the conscious and unconscious factors that lead to national antagonisms and terminate in war. I tried to develop the argument that war is essentially a preventable condition; and, because of the damage it does to the physical and mental health of many millions of people, I contended it should be regarded as a public health problem. And because of the individual and mass psychopathology involved, I considered war to be essentially a psychiatric public health problem, one in which psychiatry should exercise itself in the field of prevention. I suggested that a committee on international relationships should be formed to work in collaboration with psychiatric and mental health bodies in other countries, as well as with all the other social sciences, for effective team work. I was convinced that while the physical sciences were necessary to win wars, only the social sciences could win and keep the peace.

At that time (May 1941) the United States had not become an active participant in World War II. It may have seemed premature to hope that a country which had not yet entered World War II would be interested in preventing World War III, and I think it only fair to say that my presidential address excited scarcely a ripple of interest. Nor could I foresee in 1941, being only an armchair psychiatrist, how the social sciences would solve the practical difficulties of organization but it now appears that UNESCO and the World Health Organization are providing the basis of

union for them. Surely this is a great opportunity for national group psychotherapy, and education should be the key note. We are under a great debt of gratitude to the person or persons who coined the slogan in the constitution of UNESCO and the definition of health provided by the World Health Organization. The slogan, as we know, is "Since wars begin in the minds of men, it is in the minds of men that the defenses of peace must be constructed." And the definition of health goes something like this: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Both of these statements are great challenges to preventive and therapeutic psychiatry.

The American Psychiatric Association's committee on international relationships prepared a statement on international psychopathology for the International Congress on Mental Health held in London, England, in August 1948, in the hope that it might be used as a basis for a national mental health document. Before being sent to England, copies of it were distributed to all psychiatric and mental health bodies in the United States and Canada, practically all of which gave their support to it. It has been approved by the American Psychiatric Association's committee on public education and accepted by the council; and it has been published widely in the American and Canadian press. Out of the International Congress on Mental Health came a much longer statement on international psychopathology which has been broadly distributed, and from the congress also emerged the World Federation for Mental Health, composed of psychiatric and mental hygiene organizations, including the American Psychiatric Association and the National Committee for Mental Hygiene and others. The World Federation for Mental Health will have close relationships with the World Health Organization and with UNESCO.

More and more articles on international psychiatry are being written by psychiatrists and I urge your sympathetic interest in the part that psychiatry, along with the other social sciences, must play in the effort to achieve national and international sanity in what appears to be "a mad world, my masters."

In these mental meanderings of an armchair psychiatrist, the four points discussed appear to have little in common, although I think they all have application in the field of clinical psychiatry. As there is so little time and so little opportunity in our tense high-pressure world for dreams and for relaxation, I commend the armchair to my readers. Perhaps some wealthy foundation might see fit to endow an armchair of psychiatry in one of our medical schools (preferably mine). In such an armchair your old men might dream dreams and your young men might see visions.

The Ontario Hospital  
London, Ontario  
Canada

## SCHIZOPHRENIA: A DIENCEPHALIC SYNDROME\*

BY STEPHEN MAJOR, M. D.

When Robert Koch in 1882 identified the pathogenic agent of tuberculosis the scientific world looked hopefully toward an early discovery of a vaccine or serum which would control tuberculosis.

At the same time (1882) Forlanini devised a procedure of treatment called pneumothorax which revealed itself to be an effective weapon against certain forms of pulmonary tuberculosis.

More than half a century after Koch's discovery we still use the Forlanini method but now, perhaps, we are closer to a biological solution of the problem than ever before, through the use of vaccines and antibiotics.

Kraepelin more than half a century ago put all his hopes in Nissl and Alzheimer to find a pathological basis for schizophrenia. Great disillusionment followed their studies when no structural changes could be demonstrated.

Around that time Freud's genius unveiled the workings of the human mind and since then attempts have been made to interpret and treat schizophrenia by analytic methods.

The writer does not know whether the schizophrenic patient has had as much benefit from that approach as the tuberculous patient has had from pneumothorax, but he feels that we have entered an era when not only other methods of treatment will be employed but when attempts will be made to find the physio-biochemical basis of schizophrenia. Hoskins and many others studied the humoral biochemistry in schizophrenia with no conclusive results. The writer's belief is that the biochemistry of the individual neuron holds the secret to the problem. But in the meantime, why not define the anatomical structures involved in schizophrenia?

Evidences against the purely psychogenic origin of the endogenous psychoses are piling up. The fact that in organic and toxic psychoses we find psychotic symptoms very similar to those found in endogenous psychoses should, alone, put us on guard.

The fact that insulin and electric shock treatment can change the course of a psychosis or effect a cure is significant. Psychosurgery has succeeded in alleviating the sufferings of psychotics by severing those thalamo-cortical radiations which convey the

\*Read at the interhospital conference of the New York State Department of Mental Hygiene, Syracuse Psychopathic Hospital, May 3, 1949.

emotional component to the interpretative cortical areas. Recent Swedish studies on ganglion cell metabolism are fascinating. Geneticists insist on the hereditary nature of schizophrenia, which seems to prove that the pre-disposition to the disease is cell-bound.

The writer in a recent paper\* showed electrocardiographic changes in young catatonic schizophrenics who had no cardiac pathology. He attributed these findings to an imbalance of the autonomic nervous system. Numerous other signs and symptoms observed in this type of patient are also due to such an imbalance.

The writer believes in the biological basis of schizophrenia and puts the *locus morbi* in a well-defined anatomical structure of the central nervous system. While trying to demonstrate his point he will attempt to give an explanation, in the general framework of his interpretation of schizophrenia, for those symptoms which had satisfactory analytical interpretations, together with others which did not.

Disease processes, we know, may show a predilection for certain age groups, certain organs, or parts of a system. They may show a tendency to recurrent attacks or assume the course of a chronic disease. A good example is offered by the demyelinating processes and by the heredodegenerative diseases. In schizophrenia the same situation exists. There are certain types of schizophrenia which affect young people by predilection; another type, instead, is more prevalent among mature individuals. Yet exceptions are by no means infrequent. Also, there are the acute as well as the chronic varieties; mild cases and severe cases.

Obviously, schizophrenia acts as other disease processes do. It does not grow out of the personality; but, rather, it may co-exist with it. It seems that the personality has an organic basis; it is cell-bound, located in the central nervous system. On the other hand, organs and systems throughout the body are intimately connected with the central nervous system through the autonomic division. This organic basis of the personality, within and without the central nervous system, may harbor pre-disposing factors to a certain disease process. There are well-defined personality make-ups found with diseases such as hypertension, peptic ulcer, Graves' disease, spastic colitis, etc. Similarly, there are somatic features which generally go with these personality make-ups and diseases.

But, of course, there are exceptions when these psychosomatic

\*N. Y. S. J. Med., 48:1489-1491, July 1, 1948.

diseases appear without expected obvious psychological or somatic features. The same observation applies to schizophrenia. We may find that many patients have a schizoid pre-psychotic personality make-up or an asthenic habitus, yet there are many who have no obvious psychic or somatic characteristics of the schizophrenic type.

A schizophrenic patient, like everyone else, uses the whole battery of mental mechanisms and makes use of phylogenic and ontogenic psychological material present in the psyche. But let us see how he uses that material and why he uses it the way he does.

In the disorganized psyche of the schizophrenic patient, primary repressions, such as Oedipal and castration fantasies, come to the surface. Oral, anal, and homosexual tendencies are exhibited. This material is overtly expressed, or only faintly camouflaged in symbols, or acted out. If it represented conflicts, its ventilation in the course of the psychosis certainly does not seem to help the patient.

The projection of homosexual tendencies, so prominent in the paranoid type of schizophrenia and considered the fundamental psychopathology thereof, is only the use of a mental mechanism in this diseased condition. Reacting to false sensory perceptions, the patient draws material from psychological sources, which all of us possess because of the protracted suigeneristic training we receive in our type of civilization. By no means, however, do all paranoid schizophrenics have homosexual projections. Miss R. T. was 34 years old when first admitted to Binghamton State Hospital on January 17, 1944. She was a very good looking woman—a nurse. A year before her hospitalization, she started to hear men's voices, mainly colored men's voices. The content of her hallucinations was sexual. She barricaded herself in her room because of fear of being raped at night. She said that she was visited by men while asleep and was raped. She never saw the men but she could tell they had been there by the pain and swelling she felt in her mouth and genitalia and the taste and smell she perceived. She was hospitalized because she attempted suicide by taking a large amount of barbiturates.

Magical thinking is common in schizophrenia. If magical thinking is not phylogenically radiated in us, then in infancy we have

many such experiences. Any infant who cries because hungry or distressed, will promptly have come to him, from nowhere, a protecting hand, a nourishing breast, or at least a bottle. In terms of ego functions then, it can be said that the schizophrenic process with its overwhelming sensory experiences and vegetative imbalance disorganizes and ultimately defeats the ego defenses, causing regression to an early pre-ego, autoerotic stage where omnipotence characterizes the reaction of the individual to the objectless world of primary narcissism.

Ambivalence may be present in a normal person but in catatonies it is sometimes spectacular. Those sudden swings between the opposite poles of their emotions and attitudes are the result of the fluctuating contents of their delusions while their judgments are already destroyed.

Occasionally one observes that patients entertain death and rebirth fantasies, and what we call cosmic identification, depersonalization and other bizarre delusions. In the grip of these delusions, a patient may say that he does not have a brain or has no stomach or intestines; he may say that he is a tree or a bird, that he feels he is floating in the air, or that he is dead. These sensations, the writer believes, belong to the sphere of proprioceptive and interoceptive sensibility.

Schizophrenia can be divided into two great groups. In one we have those patients in which autonomic imbalance prevails. In the patients of the other group, false sensory perceptions prevail.

In the first group there are numerous signs of an imbalanced autonomic nervous system: hyper- or hypothermia, excessive sweating, acrocyanosis, excessive salivation or excessive dryness of the mouth; fecal and urinary retention or incontinence; labile pulse rate and blood pressure; pilomotor erectivity; rejection of food, probably due to false taste and olfactory sensations or to gastro-intestinal dysfunction; fear; rage; elation; disturbance of sleep mechanism; catalepsy. Besides all these signs and symptoms, the writer studied the electrocardiographic changes shown in a group of 52 young catatonies. The changes consisted of short P-R intervals, abnormal P and T waves in the chest lead, and frequent ST segment depressions. With our present knowledge of neurophysiology most of these signs certainly—others probably—are hypothalamic in origin.

The second group is dominated by sensory experiences which we call hallucinations. They are auditory, visual and olfactory sensations—exteroceptive, interoceptive and proprioceptive sensations. They are thalamic in their origin. The intense drama of these experiences is well illustrated by a patient's own terrified description:

D. N., 28 years old, was first admitted to Binghamton State Hospital on July 7, 1947, where he presented a picture of catatonic excitement, acute hallucinosis and homosexual panic. He swiftly recovered and was discharged. He was readmitted on March 13, 1948 because of odd behavior, such as lying on the ground in cold weather, anointing his whole body, refusing to eat meat, and expressing delusional ideas. In the hospital he was self-absorbed, seclusive and unfriendly, and occasionally was observed smiling without provocation. Having established a good transference to the writer on his previous hospitalization, the patient gave him a detailed description of his terrifying experiences. Here are parts of the interview taken on March 22, 1948:

Q. *What is it you hear in your head, voices?*

A. Once in a while.

Q. *What do they say?*

A. They are very intelligent, that is why I don't understand, do you know what *mites* are? Where is it they come from, if I may ask?

Q. *What is a mite to you?*

A. If you will listen to me and try to imagine that I am not crazy, I know what I am saying every minute. Do you know what voices actually are, I believe I do. When I left here last time I went back home and heard voices all the way down on the train. After a while there was a terrific pressure on my head. The voices seemed to travel away off on the air. The only thing I could figure out was one of these machines that shoot beams of sounds, which are too delicate for the human ear to catch. The pressure kept getting greater and greater. My wife was there. You possibly may not believe this. I have good eyes, my eyes are perfect. It is a long story, I could talk for days and days. I hesitate to tell a psychiatrist because they don't believe it. They say I am nuts, I am insane. Far be it from me to be that way.

Q. *You haven't told me what mites are.*

A. Just a minute, you will have to let me tell it in my own way.

There are millions and millions of angles to it. I could hear explosions in the distance which actually happened, even the street lights went out. I could see people running around the house, I could barely see them. I must have heard it from these voices. They tried to put it over on me, and I disappeared, people couldn't see me. Do you know how I know that? I would walk on a bus, walk right by without paying and they never asked me for fare so I know they couldn't see me. I walked all over New York City and I thought it was these gangsters in these buildings.

The voices were terrifically loud, they blared across the earth and something was shouting in my head. Then these things started flying through the air and entering my brain. I walked for two or three days and finally I fell down. A policeman took me to Kings County Hospital and the following day my wife came and got me. I went home but I couldn't get along with her. All the whole night they would snap and crack, something would appear in front of my eyes and would say, "Dan, what do you make of that one?" I would try to fight by *evolution*. I would think of carbon, what it was before it was carbon, and before that and before that.

I couldn't get along with my wife so I left and came to my mother's house. Then I started to have a prickling all over my skin. The voice told me to use plenty of oil so I oiled myself thoroughly, I used a whole gallon of oil. Little things started popping out all over me. I asked the voice what these things were and they said they were "mites." I looked at them and the voice told me that is what started the first war. They said, that is a grain of wild rice and that is what it looked like. That is how Jesus started the world. I could pop them right out of my skin. The hardest place to get them out was in the back, in the big muscles. After that I stopped eating for a while, stopped drinking and stopped smoking.

I tried to find out what my body wanted. To hell with what was inside, it was what the flesh wanted. I started eating lettuce and I found out about wheat. These voices were too God damn intelligent because wheat germs make worms. I started burning my bread before eating it, with no butter. After that these tendrils appeared, they were like what you call life worms. I would call it soul, or in other words, mucous. They came out of my skin in great quantities, they have great imaginations, they will fly right into you. I try to lose them by walking away from them.

The voice said, "Go lay on the ground." I walked about two miles away from home in Flushing. I lay down on the ground and I would shiver for an hour. It must have been something like a divining rod. They claimed that was going into me, I could distinguish all these voices screaming, and then when I got up from the ground there would be this awful stink there on the ground. That is how I could get rid of these tendrils, they would turn into worms. Even if you try to lose the damn things they would follow you right back. The following day I decided I would leave town. After I was a mile from that place these started flying into me again. That was the second stage.

I started walking from Waverly to Elmira. Whether that had anything to do with it or not, there was an automobile accident behind me a couple of miles and I could hear the crash. I could hear them talking. I got up at 3:30 when these things started crawling. I left the house; she (mother) said, "Where are you going?" and I said, "Up to Elmira to look for a job." She called the police.

The police grabbed me and wanted to get me in the car. I told them, "To hell with you, I will walk back." I walked back and they had a hell of an argument. I kept my mouth shut. I walked into Elmira and this accident that was two miles behind me, the voices kept screaming, "You are to blame." I went to the railroad track and I started walking along that for a few miles. I finally got a little sick and I lay on the ground in all that snow and the ground would pull it out of me to some extent. I went to Elmira and from Elmira I believe I came back home. Then I went back to Elmira the following day and they started coming out of my fingers, I could barely see them, long stringy things.

The voices said it was "visionists'" material. I could throw the stuff out, throw it around the telephone poles. I walked with my hands behind me like this (demonstrates) and feel the stuff pull itself out of me. I guess I walked for 18 miles. Just pulling that stuff out of me. You will have to admit it is an interesting story.

*Q. Do you think some organized gang was after you causing you to have these worms?*

*A.* I know it. I also know something else. Whether you believe it or not—I am tired of having people say I am insane. There are a hell of a lot worse running up and down, other people know it besides me. Why they pick on me I don't know. The bastards

come in and they filled me full of bunk. In the Queens General Hospital I could actually see it. You could see them running, they were throwing things into me. They were about the size of, excuse my language, but they were about the size of rat turds, they would throw them into me and they would burn into me right down through. I could feel them. I could see them, all I could think of was a bowel, or a piece of gastric tissue.

I could see the damn things, I could even smell them, smelled a little like electricity from the ground. I could see the people, I could distinguish them quite easily, so I started hooking my eyes onto them, and throwing them through the wall. They would holler like hell and the floor got all wet and started to stink. There was another person right there and they couldn't see them. A nurse came in and stood with her back to the wall but she couldn't see them. The voice said, "Dan, you will have to use your imagination or they will kill you." It was like an acid that would burn right down through me and come out my buttocks. I could feel it burn.

Q. *Did they say they would kill you?*

A. They said they would get me, probably kill me.

Q. *Did you think of killing yourself?*

A. No, I said to hell with them, I would go on fighting them to the end.

Q. *Did you mention to your mother you were Jesus Christ?*

A. I never said such a thing. At one time I said I didn't think I should eat meat because I am putting up a fight, and I know God damn well I cannot correct the voices.

• • •

Where is the origin of such a multitude of sensory perceptions?

Normally, our sensory impulses, from all over the body, stream into the thalamus through the medial, lateral and trigeminal lemnisci. The auditory and visual pathways enter into the medial and lateral geniculate bodies respectively (called also the metathalamus). Taste and olfactory perceptions are correlated in the hypothalamus. All these sensory impulses are then relayed from these diencephalic structures to the respective cortical areas for final perception, integration, and interpretation.

But the schizophrenic patient does not receive sensory impulses from the periphery; his afferent pathways are carrying no sensory impulses to the diencephalon. Yet his sensory experiences

are real to him. Perhaps something has happened to the neurons of the diencephalon which make them fire impulses toward the cortex without having received any impulses. Perhaps there is an irritating disease process in the diencephalon. If, in a case like the one illustrated in the foregoing, this disease process were in the cortex, the whole cortex would be expected to be involved, and pyramidal and extra-pyramidal signs would be only an obvious corollary to the syndrome. In toxic deliria (of alcohol, cannabis indica, uremia), where symptoms similar to those found in schizophrenic psychoses occur, we find general muscular weakness, ataxia and tremor. The toxins act on the central nervous system *in toto*. Only a localization in the diencephalon can explain such a discriminating symptomatology as that of schizophrenia, limited to false sensory perceptions, thalamic in origin; and vegetative imbalance, hypothalamic in nature.

We do not question the reality of pain in a patient suffering from phantom limb or in the many paresthesias and dysesthesias a patient may experience if suffering from peripheral neuritis, or a disease of the central nervous system. We accept the concept of referred pain because we think we understand the anatomical basis for it. To the writer, the false sensory perceptions of a schizophrenic bear many similarities to paresthesias, dysesthesias—or for that matter, to referred pain. They refer to areas from which they do not actually originate, but they may originate in neurons of the diencephalon which usually handle afferent sensory impulses from those peripheral areas.

Let us stop here briefly to consider the phenomenon called the dream. While sleep is a physiological activity regulated in the hypothalamic center of sleep, the dream is a sporadic phenomenon—possibly due to stimulation of the brain by circulating metabolites in the cerebral capillaries. The stimulation is more cortical than diencephalic. The experiences in dream are tied to conscious and unconscious memories. The experiences in the schizophrenic psychosis are delusional reactions of the interpretative centers to constant false sensory perceptions.

Why then does the psychotic schizophrenic react to false perceptions the way he does—with delusional ideation?

Normally, the cortex receives a certain quantum of sensory perceptions at a time and refers it to the interpretative areas of the cortex for concept formation. These concepts, however, are

formed in the heat of emotions received from the diencephalon and evoked there by the nature of the sensory experiences. The writer would hold that the concept thus permeated with emotion is what we call judgment. It is well-known that where there is little intelligence or where the emotions are abnormal, the judgment is poor. It is also well known that if extreme emotions such as fear or panic get hold of otherwise normal people, let us say in a catastrophe, they are said to "lose their minds." What they actually lose is their judgments.

If one reads the account of our patient's sensory experiences one readily realizes that under such intense, incessant, catastrophic sensory bombardment, a man's ego functions can be overwhelmed. Fear and panic take hold of him. His interpretative centers still function, but strange concepts are formed under the tremendous emotional stress of tormenting sensory perceptions, resulting in complete destruction of judgment, ideational delusions and disorganization of the psyche.

If such exhausting sensory experiences and emotional stresses last long, they will ultimately reduce the patient to an apathetic, dilapidated, deteriorated, chronic schizophrenic, regressed to a low level of psychic organization.

#### SUMMARY

The writer defines schizophrenia as a diencephalic syndrome. Its symptoms are attributed to dysfunctions of the ganglion cell in the nuclear masses forming the thalamus, hypothalamus and metathalamus.

Accordingly, he divides schizophrenia into two major, though overlapping, groups: one presenting predominantly vegetative disturbances, the hypothalamic type; the other presenting, prevalently, disturbances of the sensory sphere, the thalamic type.

While localizing schizophrenia in the diencephalon the writer cannot offer an explanation for the primary cause of the disease. However, he believes that the solution of the problem lies in the altered metabolism within the diencephalic neurons.

The writer offers his definition of judgment and his interpretation of (1) schizophrenic delusions, (2) the phenomenon of the dream, and (3) the relationship of the personality to disease-processes.

Binghamton State Hospital  
Binghamton, N. Y.

## THE USE OF CURARE (INTOCOSTRIN) IN ELECTRIC SHOCK THERAPY

BY REGINALD J. YOUNG, M. D.

In 1940 Bennett described the use of curare in shock therapy to modify the convulsive seizure. The preparation used was not well standardized so he hesitated to recommend it for general psychiatric practice. In recent years, a well-standardized preparation of the drug—intocostarin\*—has been available but many psychiatrists still hesitate to employ it because of the supposed added danger to the patient.

It is probably significant that the first patient to whom the writer gave electric shock suffered a severe fracture of the scapula. The crunching of the bone made a lasting impression and was the main factor responsible for the later use of intocostarin as a means of tempering the seizure in all cases receiving electric shock therapy. To date, the drug has been administered to 42 consecutive male patients. Over 1,000 individual injections have been made with no deaths and only one serious complication. Using proper precautions, it can be considered a safe drug and if used routinely, there will be no complications of bone fracture, no dislocations, no complaints of back pain—and the therapy can be carried out with fewer and inexperienced personnel.

It has been found, however, that the present system for the computation of dosage based on weight, sex and development† may be attended with danger and should be modified. The system is unreliable as it does not take into consideration individual sensitivity. The average initial dose using this formula is 40-60 units (2-3 cc.) whereas in actual practice some patients are satisfactorily curarized on as little as 20 units.

If the formula dosage is administered on the first injection, a patient hypersensitive to the drug may have a very severe reaction characterized by failure of respiration and peripheral circulatory collapse. Unless prompt treatment is then instituted, death may ensue. The writer has had only one severe reaction of this type; and it will be described later. It is of the utmost importance,

\*Intocostarin (Reg. U. S. Pat. Off.) is a trade mark of E. R. Squibb & Sons. Intocostarin is a purified extract of "chondrodendron tomentosum," assayed so that 1 cc. of intocostarin is equivalent to 20 units.

†Minimal dosage of one-half unit of intocostarin per pound of body weight, less 20 units as a precautionary measure for women of weak musculature.

therefore, that the initial injection be small, that is, 10 units or less.

Before starting electric convulsive treatment the amount of drug necessary for curarization must be determined. The writer tests each patient's reaction by first administering 10 units of intocostarin intravenously in one minute. This initial injection is the most important and if no untoward reaction occurs, there is less likelihood that any severe ones will develop when the dosage is increased. It should be administered with the patient in an upright position, sitting in a chair, as signs of muscle weakness can then be gauged much more readily than in a reclining position. If there is insufficient response, the amount is increased 10 units daily or at each treatment period until satisfactory curarization is obtained. This is characterized by extreme weakness or paralysis of the neck muscles. The greatest response develops about three minutes after the injection. If it comes earlier, that is within two minutes, the dosage should be reduced or extra time allowed before giving the electric shock. Although it is of course advisable to have prostigmine (which is a specific antidote for curare), cardiac stimulants and oxygen handy, it will rarely be necessary to use them. It is important to have a tongue clamp available, as the air passages will occasionally become blocked by the relaxed tongue. In such instances of blocked air passages, attempts at inspiration are usually observed; and as soon as the tongue is pulled forward, breathing takes place easily. Actual respiratory failure is a rarity. The usual complication, when one does occur, is a mild to severe circulatory collapse either before or after the convulsion. It is characterized by shallow respirations, weak and/or slow pulse, lack of color rather than cyanosis, and low blood pressure.

The one serious complication in the writer's experience took place after giving the first injection of curare. Immediately after its completion, the patient slumped to the floor, became colorless and pulseless, and respiration ceased. After prostigmine and cardiac stimulants were administered, abdominal respirations commenced, and within a few minutes the pulse and color improved.

Of 42 consecutive patients treated, four or approximately 9 per cent had such severe reactions to the first drug injection that use of the drug was discontinued. Seven, or approximately 17 per cent had severe enough reactions so that it was thought wise to

discontinue the drug at some time during the course of electric convulsive therapy. The rest, or about 74 per cent, showed no abnormal response to intocostin. The average dose used was 54 units, the maximum 95, and the minimum 20 units. Of the 11 patients who had the most severe reactions, only two showed significant cardiac pathology as revealed by the electrocardiogram.\*

It is frequently possible to predict the type of individual who will have an abnormal reaction to intocostin. The 11 patients who exhibited the more severe reactions showed most or all of the following objective signs. They were usually inactive on the ward, with varying degrees of actual motor retardation. Complexions were pasty and sallow. Blood pressure was low for the group, averaging 108 systolic and 77 diastolic. On examination of the skeletal musculature, mild to severe hypotonia was present.

It is the writer's opinion that intocostin should be more widely used to modify the electric shock convulsion. It is especially indicated in well-developed, muscular individuals who are the more likely to suffer bone and joint injury, and in cases where, due to bony structural defect or disease, a decrease in the intensity of the convulsion is desirable†

#### SUMMARY

1. The use of intocostin as an adjunct to electric convulsive therapy is a safe procedure if proper precautionary measures are taken.
2. A new method of dosage determination, which takes into consideration individual sensitivity, is explained.
3. It is frequently possible to predict by certain objective signs whether a patient will be over-sensitive to the drug.

Binghamton State Hospital  
Binghamton, N. Y.

\*One patient was not available for an electrocardiogram, but there were no clinical signs of cardiac pathology on examination.

†Bennett, H. E.: Preventing traumatic complications in convulsive shock therapy by curare. J. A. M. A., 114:322-324, January 27, 1940.

## PSYCHOTHERAPY, WITH FAVORABLE OUTCOME, IN A CHRONIC SCHIZOPHRENIC\*

BY EDGAR A. P. KELLERMAN, M. D.

The recent advances in brain surgery for treatment of schizophrenia have dissipated interest in the question of how much the chronic patient can be helped by appropriate psychotherapy. Moreover, the advent of shock therapies has obscured the fact that there is a phenomenon of spontaneous remission in schizophrenia, even in cases of long standing. It is necessary to return to studies of the pre-shock era to get sufficient statistical material to determine the frequency of this. In a survey of the pre-shock period, Whitehead<sup>1</sup> has pointed out a serious flaw in hospital statistics. For various reasons, the period of hospitalization does not coincide with the actual period of illness. Published statistics usually fail to take this into account. A valid study should determine the actual length of illness rather than the total period of hospitalization. Such a study was made by Tangerman,<sup>2</sup> who pointed out that in a group of 226 schizophrenics with psychoses of over five years duration, there were two spontaneous remissions. The anonymous author of *The Philosophy of Insanity*<sup>3</sup> mentions spontaneous recoveries in patients who had been ill 10 and 16 years respectively. Bleuler<sup>4</sup> observed that chronic patients, especially catatonics, may recover as a result of incidents that seem trivial to the observer.

The feeling of hopelessness with regard to the psychotherapy of chronic schizophrenia has slowly changed in recent years. Fromm-Reichmann<sup>5</sup> reviews the changing attitudes and points to the large number of workers in the field whose contributions have given reason for optimism. Barbara<sup>6</sup> cites a case treated successfully by psychoanalysis after 12 years of illness. Wolberg<sup>7</sup> records the treatment of a chronic case by hypnoanalysis. The most extensive series is that of Rosen<sup>8</sup> who has reported 38 cases treated by "direct analysis," with good results in 37 of them. Eleven of these cases were of over five years duration, most of them had had various forms of shock treatment, and were considered incurable.

The following case is that of a catatonic schizophrenic who

\*Read before the Downstate Interhospital Conference of the New York State Department of Mental Hygiene at the New York State Psychiatric Institute, New York 32, N. Y., April 21, 1948.

showed evidence of improvement after nine years of illness. He was then seen by the writer four times a week in hourly sessions for three months. After this, he followed the customary hospital routine for seven months and then was placed on convalescent status. This case is of interest because of the severity of the symptoms, the apparent deterioration, and the degree of improvement shown.

#### CASE REPORT

H. Y., aged 30, was admitted March 13, 1937 to Brooklyn State Hospital. The family history showed that one brother and one sister had been in state hospitals for many years, both diagnosed dementia præcox, hebephrenic type. The patient was the third of four siblings. From one to two years of age he spent a year in a hospital with a chronic illness. From an early age he was bookish and studious. He was a brilliant student in high school and led his class. He was graduated from college at the age of 24, was considered eccentric at this time and held numerous jobs. He was a language instructor in a large eastern university for a time. At another period he worked as a W. P. A. laborer. He was married two years before his hospital admission, and soon thereafter began to "run around with other girls." His wife left him after three months. In December 1936, she divorced him "because he developed ideas of persecution." After the divorce he began to annoy her, asking her to marry him again. Early in March 1937 he began to wet and soil himself and was committed.

#### *Course in Hospital*

On admission, H. Y. was actively hallucinating. He was manneristic and assumed typical catatonic attitudes. He would stand all day in one place and gaze at the floor. He was mute and resistive. He neglected himself completely. A diagnosis of dementia præcox, catatonic type, was made. Insulin shock therapy was given. At first the patient required restraint and daily tube feeding. After 50 treatments he began to show improvement, and treatment was terminated after 67. At this time he was seclusive and self-absorbed, manifested extreme religiosity, showed some mannerisms, but was considered well enough to go home and was paroled on July 18, 1937.

H. Y. was returned from parole two weeks later in a state of catatonic excitement and exhaustion. A pharyngeal abscess was

incised on August 6, 1937 and the patient's physical and mental condition improved within a week. A note of August 12, 1937 by a physician who had known the patient for many years described him as back to his pre-psychotic personality. Ten days later he showed a return of his former symptoms. He had 66 insulin treatments and nine combined insulin-metrazol treatments. He manifested improvement and was considered for convalescent status in December 1937. This was deferred, and a week later the patient resumed his stupor and required tube feeding. He had 26 metrazol treatments and showed slight improvement. He quickly relapsed after treatment and by August 1938 had assumed a complete catatonic attitude which remained unchanged for the next seven years.

A note in March 1940 is typical: "Deteriorated, dilapidated, mute, incontinent praecox who has reverted to the intra-uterine level of existence. Urinates in bed and defecates. He shows no response except to giggle at times, in ecstasy, especially when he is tube fed." He spoke only to members of his family at this time—and spoke in a deluded, illogical fashion. He would get out of bed whenever the national anthem was played and stand at attention, even if naked. A course of insulin treatment in 1941 produced no results at all.

The first sign of any improvement was in September 1945 at which time H. Y. expressed the desire to go home. In December 1945, it was noted that he was oriented. He said that he had had a mental upset as a result of masturbation and philandering. He still required tube feeding and continued to require it until April 1946.

The writer's first contact with the patient was early in that month. At this time he would stand all day long in one position staring at the floor. He refused to eat solid food but would drink the tube feeding mixture. He answered questions politely, although there were many days when he would not speak. He soiled and wet himself. He would go to bed in the afternoon and cover himself with his bedsheets as though it were a shroud. During Passover of that year, he insisted upon being tube fed as the food was not kosher, but after this he resumed his practice of *drinking* the tube feeding mixtures. During this time, the writer became friendly with the patient and acceded to as many of his requests as were feasible to grant.

*Therapeutic Sessions*

Near the end of April 1946, H. Y. was asked to come into the writer's office. He looked around the room and asked to be excused as the barber was shaving a patient and this had an evil influence on him. When the barber was finished, he was again asked, and this time he objected that the radio was playing. When the radio was turned off, he offered more objections until it was obvious that nothing would be accomplished by trying to give in to his wishes.

After half an hour of this, I suggested to him that if he took my hand as he walked to the office, he would be protected from harmful influences. The patient thought this over and agreed to go. Once in the office, he relaxed considerably, and talked freely and rationally. A therapeutic program was agreed upon: he was to be seen four times a week. The patient refused to talk on Wednesdays, Saturdays, and Sundays and also would not speak at certain hours because of harmful influences. The next session was occupied in doing a Bellevue-Wechsler intelligence test. The patient was interested and co-operative. He scored an I. Q. of 123 and my impression was that his real I. Q. was probably higher.

What was remarkable was the patient's complete orientation and awareness of events that had gone on during his illness. The ward had a radio which played most of the day; and, from this, the patient got all of the news. He displayed phenomenal memory of dates and events. He knew the names of all the doctors, nurses, and patients on the ward. He recalled the attitudes of all the various doctors and had a favorable word for those who were especially kind. He gave as his reason for improvement the fact that the war had ended. He felt that he was personally responsible for the war by his lapse from orthodoxy. He considered his symptoms an attempt at atonement; and the end of the war made it unnecessary for him to atone further.

Further treatment was a combination of free association with attempts to influence the delusional ideas and personal habits by persuasion. The patient was allowed to sit facing the therapist. In many instances it was necessary to reason within the patient's own delusional structure to accomplish any change. In other instances, it was necessary to promise certain privileges in direct return for giving up certain habits. It was practically never necessary to interpret to the patient, as his free associations always

led back to significant infantile material; and the patient was usually able to make his own interpretations. It was necessary to exercise considerable patience and indulgence, as he constantly imposed obstacles to treatment as a result of delusional ideas.

In one of the first sessions, he brought up the following material which he constantly elaborated in subsequent interviews. He said that when he was nine, a drunken negro exhibited his erect penis before his mother. He had expected his mother to feel disgusted, but instead his mother laughed. He felt very much hurt. He felt his mother was neglecting him. This incident started him masturbating. He felt that the penis was the only way to a woman's affection. He would fantasy in masturbation that he was making a princess laugh, just as his mother had laughed. He felt that laughter was equivalent to marriage. Later in life he developed considerable sexual feeling toward a younger sister. This sister would prepare his meals for him after his mother died. He never had sexual relations until his mother died, after which he began to philander. He preferred negro women as his sexual partners.

H. Y. gave the following associations to his toilet habits. He tried to urinate and defecate only at 12 o'clock. He related this to the legend of "Hansel and Gretel." He said Hansel and Gretel had to be back at midnight. He felt that by doing these things at 12 o'clock he was honoring his mother, and that in a magical way his mother and grandmother would become alive. He also recalled that at the age of three, his mother took him to a doctor's office. While waiting there his mother seated him on the "pottie." He was afraid and mother told him that if he sat on the pottie the doctor would not treat him. He now felt that, by withholding his toilet functions until 12 o'clock, he would stave off the needles and treatments which he feared.

H. Y. explained some of the evil influences which he felt as follows: A certain patient had an evil influence on him. This man was a Yugoslav. This reminded him of King Alexander of Yugoslavia who was assassinated and this in turn meant that some harm might come to his own father, since king and father were equivalent. Another patient had remarked that his wife had died while baking bread. This meant that bread could not be eaten in H. Y.'s presence lest some harm befall his ex-wife. The barber on

the ward or the sight of men being shaved was harmful because it recalled Samson and Delilah and the idea of loss of virility.

The patient's various delusions and habits were attacked in different ways. He was urged not to soil the bed but to use the toilets. He said that he would not do so until the rubber sheet on the bed was removed. The writer told him the rubber sheet was there precisely because he soiled. He insisted that the sheet be removed before he would change his habits. This was done and he began to use the toilet, but he still urinated in the drain in the middle of the floor instead of in the urinal. He further defended himself by saying that he was maintaining a passive resistance against the hospital and that if he ever submitted completely to hospital routines he would be there the rest of his life. As long as he resisted the hospital, he felt that he had a possibility of freedom. The practical absurdity of this was pointed out. By this time, H. Y. had enough faith in the writer, and had gained certain privileges, so that this appeal had merit. On June 11, 1946, the patient began to use the toilets in the proper way and never relapsed.

On another occasion, the writer urged him to do some simple task on the ward. He agreed and was assigned to the task of wiping the bed trays clean after each meal. He began to do this work at the noon meal only and to neglect the other two meals. He gave as his explanation for not working during supper the fact that Franklin D. Roosevelt had died at about 5 o'clock in the afternoon and he was accustomed to observe an hour of silence and immobility in F. D. R.'s memory. I pointed out that F. D. R. was a man of great activity and great interest in his fellow-man. The proper way to honor a man like F. D. R. was by activity that benefited others and not by silence and inactivity. He agreed with this and promised to work during supper, but in the next few days, he still did not work during the supper hour. He was questioned about this, and said sheepishly, "Frankly, Dr. Kellerman, I get tired by suppertime and I like to go to bed." This explanation was considered an improvement in that the patient had substituted a real reason for a delusional one.

There were a number of instances that called for considerable patience on the part of the physician. On one occasion H. Y. stood mute and immobile on the ward and refused to come into the office. He would not speak or answer. The writer told him that he

probably had a good reason for not speaking and that he would see him at the customary hour the next day. As the writer left the ward, the patient called out and came promptly into the office. He explained that as the writer was speaking to him the writer inadvertently had put his foot on another patient's bed. This patient had an evil influence over H. Y. and H. Y. could not speak to anyone who had any indirect connection with this patient. On another occasion, H. Y. asked to be excused from an interview on the grounds that Booth Tarkington had died on the day before and he wished to observe 24 hours of silence in his memory. This was permitted, but he was asked to make up this hour on Saturday. He wanted to be excused for religious reasons. The writer pointed out the necessity for a certain number of hours of treatment each week and said that treatment would be wasted if continuity were not maintained. The patient agreed to an interview the following Saturday despite his religious feelings.

Intensive treatment was carried out for three months; and the man was seen less frequently the next three months. The writer was then transferred to another department and was unable to have much contact with him. At this time he was well enough to go to occupational therapy. He began to do finger painting under the direction of an occupational therapist who took great personal interest in him. He responded very well to the finger painting. On March 19, 1947, he was placed on convalescent status, as much improved.

H. Y. adjusted well on convalescent status. He lived at first with his father in a furnished room, but after several months went to live by himself because of friction with the father. He went to school evenings and took a course in photography, which has since become a hobby. He made attempts to get work, but was unable to and is being supported on home relief at present. He spent about five hours daily writing his autobiography, and by January 1948, finished it and has been editing and revising it. He has renewed many of his old friendships and makes good social contacts. He has had no sexual relations since leaving the hospital, but relieves his tension by masturbating, over which he has some guilt.

On June 28, 1947, a Bellevue-Wechsler test was done, and he scored an I. Q. of 138. There was no evidence of any defect in abstract or conceptual thinking.

In the summer of 1947, H. Y. mentioned that he received mental messages from people and that he had nearly gotten into fights over these. These mental messages were always related to an immediate situation. For example, at a dinner party he took a large helping of cheese and received a mental message from his hostess saying, "What a pig you are." It was difficult to determine whether these messages were projections, or were perceptions of the unconscious hostility of others. He insisted that the messages were real and stated that mental telepathy was receiving recognition as a scientific phenomenon. This situation was handled by referring him to Eisenbud's works. The difference between conscious and unconscious thinking was pointed out, and he was told that, in Eisenbud's opinion, only the unconscious was perceived by telepathy. He was told that he was not to act upon people's unconscious thoughts, but only upon their conscious statements and actions. He was told of the universality of hostile and aggressive thoughts in everyone's unconscious, and informed that it was the task of all of us to live in harmony despite our heritage of unconscious hostility. This was acceptable to him, and he began to control his actions from then on. He still received mental messages, but did not answer people back or get into trouble over the messages.

H. Y. was discharged from Brooklyn State Hospital on March 19, 1948, after a year on convalescent status, as much improved. He is pleasant and affable, makes excellent emotional contacts with people, and is busy and active. He still makes personal contacts with the writer by letter, telephone and personal visits. He is also attentive to his former occupational therapist, and in smaller degree to various others in the personnel of Brooklyn State Hospital. He still has psychotic residuals, and is dependent upon the therapist for support, but the degree of improvement is remarkable. The patient himself attributes his improvement to the efforts of the writer and the occupational therapist.

#### DISCUSSION

This case is presented as a remission in a chronic schizophrenic which began spontaneously and which was aided by intensive psychotherapy. It is the writer's opinion that both spontaneous improvement and psychotherapy played parts in the remission, and the role of each must be evaluated. In the case of this patient the

accidental factor in the spontaneous improvement was the end of the war. It is true that his illness predates the war, but he obviously took the war itself into his delusional system and, in his omnipotent way, held himself responsible for it. When it ended, he was able to speak spontaneously and thereby make himself accessible to psychotherapy.

The "Schreber case" of Freud<sup>9</sup> is a good example of the spontaneous evolution of a delusional system, in which a patient who is violent and disturbed improves and becomes tractable, although still psychotic.

There is further evidence in the present case besides the patient's own statements. During his illness it was possible to induce him to speak under intravenous sodium amytal or pentothal. This was done many times, but never with a permanent therapeutic effect. Moreover, it happened that many of the hospital physicians were personally interested in this patient throughout his illness, and numerous attempts were made to establish contact with him. Apparently it took more than willing and skillful psychiatric help in this case to make him accessible. We must credit the vagary of his delusional system and its evolution for this possibility.

Nevertheless, it required active psychotherapy to convert this possibility into a social recovery. For seven months following the patient's first sign of improvement he continued to soil and be resistive. It is probable that without the psychotherapy he received he would still be in the hospital.

It is important to study the therapeutic process in cases of this kind. Early psychiatric writers were pessimistic in regard to the psychotherapy of the psychoses. Freud<sup>10</sup> considered psychoses "narcissistic" regressions of the libido and felt that schizophrenics were incapable of forming therapeutically useful transference relationships. Fromm-Reichmann,<sup>5</sup> Eissler,<sup>11</sup> Knight,<sup>12</sup> and many others have disproved this. All workers with schizophrenics have emphasized the peculiar nature of the transference relationship and its differences from transference in neurotics. Schilder<sup>13</sup> says bluntly, "We have to show the schizophrenic positive counter-transference more openly." Knight<sup>12</sup> emphasized the necessity for optimism in all cases. Eissler<sup>11</sup> points out the schizophrenic's capacity for sensing unconscious hostility in the therapist and in the environment. He feels that it is necessary for the

therapist to regress to the level of the patient and enter into his delusional system. Rosen<sup>7</sup> holds that the therapist must approach the patient without any attitude of hostility and be prepared to go to extreme lengths to avoid any rejections of the patient.

What are the apparent dynamics of treatment in the present case? It is true that H. Y.'s symptoms were attacked by argument and persuasion—frequently within the framework of his delusional system. But what is the nature of the transference relationship that permits such persuasion to be effective? The key to this was seen in the first therapeutic session. At that time, the therapist took the patient's hand and promised to protect him from harm. The therapist became the all-protecting father. This father is a good, forgiving father who relieves the patient's guilt and anxiety. The patient is filled with Oedipal guilt, and this new father reassures him. He can tell this father of his feelings toward his mother without fear of punishment. He tests the patience and forbearance of this new father and finds he can be trusted. The hospital situation sets limits to the demands of the patient, and the new father himself makes demands for which the patient is appropriately rewarded. In this way the patient is slowly re-educated.

Is this treatment a psychoanalytic treatment? It certainly cannot be considered an analysis in the strict sense of the word. This treatment is best called a "transference therapy" in which a transference relationship is set up between the therapist and the patient, and this relationship used as a therapeutic lever. This transference is never analyzed and in this case was not even dissolved.

There is an appropriate moral in the present case. Most of the published case reports on psychotherapy in schizophrenia come from private sanatoria. Equal results can be obtained within the confines of state institutions. Adequate staffing and a staff free enough to devote time to therapy are required. The importance of occupational therapy in H. Y.'s improvement should be emphasized. The frequent use of the word, "deterioration," should not blind one to the possible therapeutic results that may be achieved. This patient was considered deteriorated by all who saw him. Yet his apparent habit-deterioration bore no relation to the actual mental capacity or to the degree of personality recovery that was possible. This case points up the possibilities inherent in a thera-

apeutically-minded approach to state hospital psychiatry. Such an approach is more than the mass production of shock treatments, and involves personal interest in the patients on the part of physicians and ward personnel. For instance, H. Y. was called to the doctor's attention by an attendant, who was aware of the turn for the better the patient had taken.

There is need for further research in the psychotherapy of chronic schizophrenia, especially along lines suitable for large mental hospitals. The present writer was associated with Brickier in a group therapy study at Brooklyn State Hospital and handled a group of chronic patients. The study is still in progress, and nothing has been published on it to date. However, in the chronic group, nearly half the patients, one of whom had been hospitalized for eight years, were able to go home. The group therapy had been supplemented with considerable individual therapy and special attention.

Without going into the question of what the therapeutic factors were here, it can safely be said that a number of patients improved enough to go home with much less total time spent in therapy than was spent upon the patient presented in this paper. Further work along the lines of psychotherapy should result in the salvage of many so-called "incurable" cases.\*

815 Park Avenue  
New York 21, N. Y.

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\*At time of printing, the patient has maintained his improvement, despite his father's death in 1948. He is not working, but is attempting to write for publication, and has written several short stories and essays.

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## THE AVERTED GAZE

BY MORRIS D. RIEMER, M. D.

The inability to "look the other fellow in the eye" is an expression in common parlance and generally indicates a state of "shame and fear." Where this difficulty is pronounced and repetitive, the individual may be said to have an averted gaze—which is regularly accompanied by a turning away of the head and neck. Such a position, maintained for many minutes at a time in the company of another individual, lends a bizarre appearance to the person involved.

Some patients with this symptom automatically maintain a physical separation of several feet from the nearest person, cross to "the other side of the street" in anticipation of "running into someone," refuse to enter the house when they know "company has arrived," and invariably break appointments for social engagements. During psychotherapeutic sessions, instead of having a "face to face" meeting, they avert not only the eyes, head and neck but the whole torso, so that the anterior-posterior axis of the patient's body is at a full right angle to that of the examiner's. In individuals presenting an averted gaze, there is, thus, not only a concomitant turning away of the body, but, as will be shown herein, an aversion of the whole emotional being.

The behavior of six patients with this symptom is reported here. None of them was consciously aware of the symptom prior to treatment. When first apprised of the difficulty, they attempted to "correct it" by forcing themselves to look at the examiner. This self-discipline, however, induced great discomfort, a reaction which clearly revealed that the averted gaze helped to overcome the underlying suffering and was of great unconscious value as a defensive measure.

In tracing the incipience of their abnormal gaze, these patients find its presence as far back as they can recall. At certain clear-cut intervals, the averted gaze disappears and the individual is able to look the other fellow in the eye. It is because of the frequency of these free intervals that the sufferer is not fully aware of the presence of his symptom. When the patient becomes absorbed in his own over-talkativeness, theatrical demeanor, argumentativeness, the expression of denunciations toward others, or any manifestation that builds up his self-esteem, the averted gaze

disappears. Further, when his discussions are totally impersonal, his difficulty seemingly vanishes. In other words, on finding a substitute that will "raise the value of his ego," he can temporarily dispense with the protective symptom of the averted gaze.

Of the six patients, four are men, and two women. Their ages are from 20 to 32. Three are divorced. Two men are bachelors. One woman is married. Two of them had hospital admissions, prior to treatment, because of acute anxiety attacks. Both parents of five patients are alive. The sixth patient's mother is alive—his father died when he was five. Close investigation of the parental milieu reveals, in each one, a consistent and severe deprivation, or lack, of affection at the hands of both parents. The marked over-protectiveness, on the part of the mothers of three patients, was severely traumatic. All six patients have been unable, because of the parental set-up, to become intimate, or to establish any companionable relationship, with either parent throughout their childhood and adolescence. They remained estranged from their parents.

Of the four male patients, it is most interesting to note, the fathers are totally unapproachable. Two men report almost identical stories. Their fathers, they say, are stubborn, keep entirely to themselves, have practically nothing to do with the family, go into impossible "crazy-like" tantrums if they are not allowed "their own way" and are for the most part silent, self-contained, unapproachable and obviously "peculiar" men. A third man, whose parents are separated, meets his father at infrequent intervals but feels that his father is also "very peculiar," is a silent "ne'er-do-well," weak, colorless, unreliable and in a sense an "out-cast" from his home and the community. The fourth man's father died when the patient was five—he has but little recollection of his father except that he was "ill" with colitis for a number of years. The mother in these cases is clearly the dominant figure, and is active in providing economically for the family. All of these men are more afraid of their mothers than of their fathers.

In the family settings of the two women, the mothers appear to be the "weaker" or "much less important members." The fathers are regarded as being "capable and talented," although inadequate and rather reserved in their make-ups. Both women patients spend much more time speaking of their relationship to their fathers and mention their mothers infrequently. The strik-

ing depreciated role of the parent of the same sex in each and all of these patients may be an important factor in the development of their specific type of clinical picture. Likewise, the relatively increased admiration for the parent of the opposite sex is of significance.

All these individuals have pronounced sexual difficulties. The two women and two of the men patients are overly shy, awkward in the presence of the opposite sex and almost totally abstinent. The other two men are quite infantile in their relationship with women, whom they seek out as clear-cut mother substitutes. They evince no signs of any romantic drives and are only concerned with the immediate "mothering" they receive.

The feelings of being unwanted came up very early in the treatment of these patients. They recall that their parents were either too busy, too preoccupied, or so involved with themselves, that they had little time to show feeling for their offspring. A peculiar similarity of description in most of these cases is that the parents rarely looked at their children. In these homes, the children did not find demonstrativeness or warmth on the part of their parents. The home was usually a quiet one without signs of liveliness. As a result of this parental attitude, the child invariably became secretive and withdrawn, and could not talk of his difficulties to those about him. The feeling of the patient was that if he asked for anything, he would only be rejected. This distressing feeling of being unwanted has carried through to the present in all of them.

In relationship to their friends, acquaintances, business associates, they have the same reactions. They inwardly feel that no one wants to have anything to do with them. They constantly look for evidence to confirm this suspicion in their minds. Finding a neighbor or friend somewhat preoccupied, is sufficient indication, to them, that he is unfriendly. When a nearby individual seems tired, they interpret the tiredness as evidence of being bored with them. Likewise, in the transference relationship, these patients constantly feel rejected. They repeat that the examiner is unwilling to be with them. They are usually surprised that he agrees to see them again. They try to find little signs to prove to themselves that they are unwelcome. Being called in a few minutes too late or having the appointment changed, or any other minor incident is "proof" that they are rejected.

Each one of these patients has "moody spells." These spells last from several minutes at a time to several months. One patient reported that one summer, she did not feel like seeing anyone and remained in her backyard to read books. Another one experiences such periods that last three to seven days, during which time, he gives up contact with everyone, refuses to see his customers, and spends his time at home, or going to the movies. During these periods, this man sits for hours in one place with head bowed, sad facial expression, and apparent deep absorption of thought. The patients report that they are consumed with an endless series of gloomy thoughts. They review in their minds the multiple hurts they have endured, the incessant rejection and sadness of their plight.

A characteristic reaction during this period is that of "getting even with the world." There is considerable hidden resentment which the patient then feels. He entertains some vague wish that, in getting even with the world, he will hurt the one he is angry at. The "not-looking" is all the more pronounced at these intervals and is a vengeful means of shunning those about him. Unfortunately, these individuals have great difficulty expressing resentment and have to resort to this indirect method as a vehicle for their hostility. The characteristics then of the "moody spell" are marked depression, complete withdrawal and a covert hostility toward the world.

Another common difficulty in these patients is in talking. The tone of voice is usually low and subdued in the presence of people whom they regard as "important"; they cannot readily express their thoughts. This inhibition of vocal expression may be so marked that the patients become mute for many minutes at a time. They invariably state that speaking becomes more troublesome when a member of the opposite sex is present. Because of obvious embarrassment, these patients dread social contacts.

Detachment in such individuals is present to a striking degree. This is shown in the facies, in the eyes and in the expression of the voice. The detachment can be severe so that the patient does not hear what is said to him or assumes a trance-like attitude. During states of intensive detachment, these patients are given to a great deal of ruminating and to constant reflecting. Many such persons have consciously cultivated a state of detachment. They

feel that in this way they are protected against rejection from others and they get a sense of feeling safe and independent.

As indicated previously, they are most immature in their sexual drives. Because of their great need to be loved, they want to possess the love object completely, and they have fantasies of getting the most beautiful, richest, competent mates for their companions. They are constantly critical of the love object if he or she does not meet their expectations. Accompanying relationship to the opposite sex, are strong feelings of jealousy, guilt or manifest hostility. As an example, the behavior of one of the male patients may be cited. He insisted that his wife wear only clothes of which he had approved. He brought home very drab, unattractive-looking garments for her and insisted that she remain at home while he was away. He refused to let her use any make-up. In this manner, he apparently hoped to keep her from being attractive to other men. Another patient constantly fantasied his winning some very rich, intellectual woman who would provide him with "everything" so that he would not have to work. These attitudes indicate an excessively powerful mother fixation, and an extreme need for protection from the love object.

When asked to explain the reasons for their "not looking" the writer's patients say "a feeling of being rejected" envelops them. They trace this back to childhood and can clearly see, after some treatment, that this feeling was first felt toward the parents. An additional reason for "not looking" is hostility to the person with whom a patient may be. To a number of patients, "looking" means flirtation—a type of flirtation that is forbidden, and therefore accompanied by a great deal of guilt. The patients complain of pronounced embarrassment or shame on looking. This embarrassment accompanies either strong hostility or sexual feelings.

In reviewing the foregoing findings, one might conclude that these symptoms are present in most cases of averted gaze. It is to be pointed out, however, that in this type of disturbance, a certain group of symptoms seems to be rather characteristic. It is found that multiple factors result in the averted gaze. A very important cause is the "not looking" of the parents or the absence of positive advances toward the child in early infancy. Because their parents did not look at them, the children in turn—in order to salve their hurts—did not look at the parents. In this manner, the child develops a feeling of defense—defense against

seeing the indifferent or cold parent. Additional factors are strong scopophilic and exhibitionistic drives which are repressed and disturbing. Because of the weak parent of the same sex, there is necessarily increased hostility, envy and resultant guilt toward that parent. The overpowering fantasies and resultant guilt provide additional impetus to this symptom.

That the strong feeling of rejection is a primary factor may be confirmed by the fact that the averted gaze can be immediately remedied by a patient's compensatory means of increasing his self-esteem. These individuals, as children, felt rejected because they were "not looked at." There is a strong fear of seeing the "rejection" in the "look" of others, as they originally sensed it in their parents. These patients speak of the severity that they saw in their parents' eyes and constantly dread the re-experiencing of threatening "looks" in those about them.

The eyes are superb vehicles for carrying warm, positive affection. When the child senses a stimulating gaze, his eyes are attracted to the gazer. The absence of this stimulus—as in parents who suffer from an averted gaze themselves, or cannot offer a magnetic welcoming glance—naturally means the lack of this activating influence. The parental eyes, lacking "giving qualities," such as love, vivaciousness, warmth and encouragement, do not supply the need expressed in the child's eyes; dissatisfied, he averts his gaze.

By far the most convincing evidence of the "protection" provided by the averted gaze to the patient, is obtained from the transference reactions. The obvious discomfort in "looking at the examiner" shows the great need for "not looking." The patient, with great difficulty and only after constant reassurance, describes his discomfort as a feeling that he is disapproved of; he senses this reaction and "murderous hatred" in the "look" of the examiner. This typical pattern is correlated by the patient to the experiences throughout his life with his parents. Because of overpowering negative transference, it is most difficult to get these patients to approach their Oedipal difficulties. The clinical picture leaves no doubt as to the inundating Oedipal fixations, with the attendant hostility, and guilt with castration fear. The hostility and guilt, however, appear to be superimposed upon the earlier primary influences that erected the defensive averted gaze.

The whole negative picture and the profound detachment resemble catatonic rigidity and withdrawal. Two of these six patients, while in the hospital, were diagnosed catatonic dementia præcox. The others also appear to be ambulatory schizophrenics of the catatonic type. This symptom complex of an intensive averted gaze is pathognomonic of schizophrenia, in the writer's opinion. To be distinguished from this type of disorder, however, is the transient aversion of the gaze that is provoked by guilt due to Oedipal conflicts or currently exciting influences. The distress accompanying the latter is readily resolved and is not accompanied by a persistent withdrawal or other negativistic reactions. Moreover, there is a clear-cut difference in the very expression of the eyes, which are dull and lifeless in individuals with the averted gaze, but are invested with a great deal of positive affect in the ephemeral disturbance of gaze due to guilt feelings.

The prognosis for patients with the averted gaze is not good. They tend to withdraw all the more when any responsibilities come their way and can only be relatively comfortable when they do "nothing" and avoid "contact" with reality. The underlying disorder usually becomes progressively worse with periods of disturbance requiring hospitalization. Psychotherapy may serve to allay some of a patient's distress, but in the long run, is relatively ineffective in resolving major conflicts. Perhaps, with better knowledge and management of the transference situation, results with such individuals may prove to be more encouraging.

#### CONCLUSIONS

1. The averted gaze is accompanied by a turning away of the head and neck and an emotional withdrawal from reality.
2. Parental influences are responsible for this symptom. It is found that the parents of such patients do not offer warm or "positive, stimulating looks" to their offspring. The parent of the same sex is usually the "weaker" and hence does not stimulate sufficient identification in the child.
3. These patients suffer from paralyzing sexual conflicts, feelings of being unwanted, "moody spells," difficulties in talking, pronounced detachment and intense hostility toward the world.
4. The transference phenomena during treatment provide material to show that the major pathology revolves about the threat to the patient's self-preservation, and is pre-Oedipal.

5. The fixedly averted gaze is indicative of a schizophrenic disorder, usually catatonic. In the differential diagnosis, the ephemeral and more common type of aversion of the gaze that is prompted by guilt or anxiety over Oedipal conflicts is to be distinguished.

410 Eastern Parkway  
Brooklyn 25, N. Y.

## RE-ANALYSIS OF AN ALLEGED TELEPATHIC DREAM

BY ALBERT ELLIS, Ph.D.

Not being content with his original reply to my critique of alleged "telepathic" findings by himself and other analysts,<sup>1</sup> Jule Eisenbud has published a strikingly graphic "answer" to my criticisms.<sup>2</sup> Eisenbud's new article is notable for its clarity, wit, and intellectual honesty—as well as its complete disregard for the scientific principles relating to telepathic studies which I attempted to delineate in my critique.

Briefly, Eisenbud attempts to refute my position—which was that he and various other analysts are scouting scientific thinking by reading into their analysands' dreams "telepathic" phenomena which have a very dubious objective existence—by citing still another "telepathic" dream of one of his patients. This particular dream, Eisenbud avers, "telepathically" analyzes his controversy with me, and "sees" into his difficulties and embarrassments in replying to my critique when the dreamer, his analysand, could not possibly have known anything about our then unpublished differences. Consequently, Eisenbud contends, the mere fact that his analysand did, through her dream, see into his innermost thoughts and emotions, and the fact that she did unearth, without any direct communication from him, his concern (which was then only in typewritten form) about my critique (which was then only in proofs)—these facts prove that my critique was written in vain, since telepathy in analysis in general, and in Eisenbud's analytic patients in particular, indubitably exists.

I could, at this point, merely re-hash the criticisms I made in my previous paper, and show that this new "telepathic" dream presented by Eisenbud is no more convincing than the previous "telepathic" dreams presented by him and other analysts. I could point out that: (a) Eisenbud (as he admits with scrupulous honesty) is completely biased in favor of the telepathic hypothesis that he presents; that (b) even without directly informing his patient of his controversy with me, he could easily have indirectly and unconsciously have done so; that (c) if he ceaselessly watched *all* the dreams of *all* his patients at the time he was concerned with writing his reply to me, it would be almost inevitable that he find dream coincidences that seemed of a "telepathic" nature; and that (d) his analysis of his patient's dream, while indubitably bril-

liant and ingenious, consists merely of a forced dovetailing of the manifest, associational, *and* latent aspects of this dream with every conceivable manifest, associational, *and* latent aspect of Eisenbud's personal life—no mean feat, to be sure, but certainly one not impossible of accomplishment, on a thoroughly *non-telepathic* basis, by such a distinguished and subtle analyst as Eisenbud.

I could, as I say, make these points, with considerable detailed supporting evidence, against the allegedly "telepathic" character of Eisenbud's new dream material. Such a statement on my part, however, could result in Eisenbud's coming forth with still another "telepathic" dream of one of his patients, which would presumably prove that my criticism of the "telepathic" quality of this third dream was unjustified; whereupon I would have to publish a rebuttal; whereupon he would have to publish a fourth "telepathic" dream; whereupon I . . . Well, it is obvious where such tactics would get us and the readers of this journal!

The matter, however, is really a very serious one. For whereas it seems certain that I shall never convince Eisenbud that his method of reading "telepathic" occurrences into his analysands' dreams is unscientific and unjustified, I am very much afraid that he may persuade many psychiatrists and psychologists to spend considerable time looking for, and perhaps reading into, ordinary dream material "telepathic" occurrences which are very dubiously present. This, at a time when there is so much vitally important psychiatric, psychoanalytic, and psychological research to be done, and so pitifully few trained personnel to do it, would seem to me to be something of a catastrophe.

I shall make, therefore, this one final attempt to point out, not to Eisenbud, but to some of the readers who may possibly have been misled, the serious error of his analysis. I shall do this, not by directly criticizing his method—since I have nothing to add, in this connection, to my previous critique of it—but by using it to reduce itself to its own logically absurd conclusion. That is to say, I shall take the very same patient's dream which Eisenbud has used in his last article to show how it is just as "telepathically" applicable to a number of other situations as to the one Eisenbud has made it applicable to. I shall show, in other words, how the very same dream which Eisenbud claims has "telepathically" foreseen his own thoughts and emotions, applies equally well to the thoughts and

emotions of two other individuals who are hardly intimately related to Eisenbud or his patient—and apply to a purely fictional character in the bargain. My purpose in so doing will be to underscore my basic objection to the kind of “telepathic” analyses which Eisenbud and several other analysts are unfortunately doing at present: namely, my objection that they are making obviously forced and circumstantial analyses which could be applied to numerous other instances and individuals than the ones to which they say the dream events “telepathically” *must* relate.

I shall now take the dream of Eisenbud’s patient, exactly as he records it in his latest paper, and, by using just the kind of analytic interpretation that he uses (though attempting to keep it more manifest than he often has done), I shall show how it can be made to apply “telepathically” to three individuals, A., B., and C., all of whom have had some contact with analysts. Individual A. will be myself; and the period of my life I shall use in relating myself “telepathically” to the dream of Eisenbud’s analysand will be the same period he uses for himself: namely, the end of October 1947, when my critique of his original article had just been set in proofs, and when his answer to my critique had just been typewritten but not yet printed. At this period of my life I was undergoing a didactic analysis.

Individual B., to whom I shall now attempt to relate Eisenbud’s patient’s dream, is an Italian girl of 20, who at the time Eisenbud’s latest article appeared in print (July 1948) was undergoing analysis with a leading American analyst (who is not personally known to me, and with whom I have had no direct contact).

Individual C., to whom I shall attempt to link “telepathically” the dream which Eisenbud contends saw “telepathically” into his own thoughts and emotions, is the hero of Stuart Engstrand’s novel, *The Sling and the Arrow*, which was published in 1947, and which was doubtless in the hands of its publisher many months before the controversy between Eisenbud and myself began.

The dream of Eisenbud’s patient to which I shall now “telepathically” relate individuals A., B., and C. is herewith quoted in full:

“I had a lady analyst. I drive somewhere with her in the rain. I meet her family. As we’re going wherever we’re going, she’s talking about her work with patients and I sense her insecurity because her talk is along these lines: ‘I sometimes wonder how

much good I do people. Every now and then I wonder if I do them any good at all—but then I must do some good,' and she names some prominent person. 'Look at so-and-so. He has great respect for my work. If he says so, it must be good,' and she keeps on in this monologue. So I try to reassure her, but first I tease her a little. I tease her about giving so much money to charities she likes, and tell her this is a guilt manifestation. But when I see she's really concerned and doubtful, then I really reassure her and tell her, 'Of course you are doing a good job.' But the more I tell her this, the more I begin to doubt her myself. I have this double reaction—the external one and the internal one. Then we get to wherever we are going. We have a car and bags and so forth. I find that I have to do everything myself as she is scared and helpless, and I make a note of this fact. I eventually park the car and take the bags into a department store." (Ref. 1, pp. 103-104.)

Just as Eisenbud has done, I shall now analyze every segment of this dream of his patient, and show how it "telepathically" applies to events in the lives of individuals A., B., and C.

"*I had a lady analyst.*"

A. In October 1947, at the time of Eisenbud's patient's dream, I was undergoing didactic analysis with a male analyst; but I had a series of dreams in which I was being analyzed by various female analysts.

B. Miss B., who was undergoing analysis in July 1948, had just started being analyzed by a male analyst; but she had not determined to continue with him yet, and was considering going to other analysts, including, possibly, a woman analyst.

C. The hero of *The Sling and the Arrow*, Herbert Dawes, is a feminized male with distinct homosexual and bisexual tendencies. He goes, a few times, to see a male analyst, whose treatment he strongly resists, because he tries to get Herbert to see his own latent homosexuality. Herbert is completely confused by his own masculine-feminine tendencies.

"*I drive somewhere with her in the rain.*"

A. In October 1947, I was considering affiliating with a mental hospital, and I arranged to drive out there to see the place. I was concerned lest it should rain that day, since it was quite warm and I did not know whether to bring along a topecoat. Also: one of the problems of my analysis at this time was that I was liter-

ally *deluged* with work, and I had to decide which tasks I would drop and which I would concentrate upon. The main question was: Which way should I turn my *drive*?

B. Miss B., when she started her analysis, had been learning to drive, and was concerned about passing her driving test. She was also, because of her driving, and because of her vacation which was soon to start, concerned about the unusually rainy season experienced in the northeastern part of the United States in June and July of 1948.

C. Herbert Dawes is terribly concerned about water, since he almost kills his wife while they are swimming, and he becomes frightfully disturbed when his latent homosexual tendencies are aroused by his wife's saving a neighbor's little daughter from drowning. Driving plays a considerable part in his life, since he meets, while driving, the man who most arouses his latent homosexuality, and the woman with whom (for thoroughly neurotic reasons) he has a peculiar hetero-homosexual affair.

*"I meet her family."*

A. In my dreams about my analyst, I once met his family, and actually went on a trip with them. Also: In visiting the mental hospital where I might affiliate, I met the new "family" of people with whom I would be working if I did join the staff.

B. One of Miss B.'s main reasons for her analysis was her recent mixed-up affair with a boy whom she had known for a time. Ordinarily, she never got involved with the families of the fellows with whom she went, but in this case, to her concern, she had met and got somewhat involved with his family.

C. Herbert Dawes has a great deal of trouble when he meets his family again, as his mother and sister come to visit him rather suddenly and unexpectedly. He also has considerable trouble with his wife since she wants to get pregnant—that is, in the family way—while he dreads her bearing a child.

*"As we're going wherever we're going, she's talking about her work with patients and I sense her insecurity because her talk is along these lines: 'I sometimes wonder how much good I do people. Every now and then I wonder if I do them any good at all—but then I must do some good,' and she names some prominent person. 'Look at so-and-so. He has great respect for my work. If he says so, it must be good,' and she keeps on in this monologue."*

A. One of the things which I was concerned about in October 1947, was whether I should continue to do as much professional writing as I had been doing. Even though several prominent colleagues had taken favorable note of my published work, I sought some reassurance from my analyst concerning it. Also: I had some doubts, at this time, about the suitability of my analyst for me, even though he had been highly recommended by prominent persons and had an excellent reputation.

B. Miss B., at the time of her analysis, had some doubts about her ability to make successful alliances with men, even though she had recently had some prominent men testify to her amative ability in the best possible way—namely, by falling in love with her themselves. She sought reassurance from her friends and from her analyst.

C. Herbert Dawes doubts his masculinity at times, even though a prominent doctor in his community keeps reassuring him in this connection. He also doubts his ability as a dress designer, and makes arrangements to turn over his flourishing business to his partner, even though scores of prominent actresses and other women will testify to his designing ability. At times he seeks reassurance from his partner about this ability.

*"So I try to reassure her, but first I tease her a little. I tease her about giving so much money to charities she likes, and tell her this is a guilt manifestation."*

A. At the time of my didactic analysis, I was being teased about making contributions, both of time and money, to scientific causes. My teaser, a girl, kept pointing out that I could do much better for myself if I thought less about science and society in general (expiation of guilt feelings) and more about myself and my own pocketbook. My analyst, too, pointed out that my supposed altruism might involve expiation of guilt feelings.

B. One of Miss B.'s close friends kept teasing her about spending her money on her favorite charity—herself—rather than saving it, as he thought she logically should do, to make certain that her analysis could continue. He thought that she might be unconsciously punishing herself by deliberately sabotaging her analysis, and thereby leaving herself in the clutch of her serious neurotic trends.

C. Herbert Dawes expiates his guilt over his feminine occupation—the designing of dresses—by virtually giving his business

away to his partner. Then he teases himself for doing so, and thinks of taking it back again.

*"But when I see she's really concerned and doubtful, then I really reassure her and tell her, 'Of course you are doing a good job.'"*

A. My analyst was rather reassuring (or at least I interpreted his attitude as being a reassuring one) about the kind of work I was doing at the time, and about the kind of work I was planning to do. Even more so, I kept reassuring myself that I was doing a good job.

B. Miss B. was reassured by both her analyst and her friends that she had been doing a good job of attracting men, and that she was in general getting along better in life than she sometimes imagined she was.

C. Herbert Dawes' wife and his best friend (a physician) keep reassuring him that he is really quite masculine, and is a good husband. His partner also reassures him that he is still a good designer when he feels that he is failing in this respect. His analyst reassures him that his neurotic symptoms will pass away.

*"But the more I tell her this, the more I begin to doubt her myself. I have this double reaction—the external one and the internal one."*

A. The more I reassured myself about the work I was doing, the more I tended to doubt its value. I got the double reaction—that the papers I was publishing were externally impressive, but that internally, as far as my own professional development was concerned, I might be doing something more worth while.

B. The more Miss B. reassured herself about the external progress of her analysis, the more she began to doubt herself and to wonder whether she wasn't holding some vital internal material back.

C. The more Herbert Dawes got reassured, by others and by his own acts, about his masculinity, the more he came to doubt it. He began to be caught in a steady double reaction—the external (masculine) and the internal (feminine) one.

*"Then we get to wherever we are going. We have a car and bags and so forth."*

A. I began to see my way, eventually, toward an analytic synthesis, and became re-convinced that I had sufficient endowment, drive, and learning to get to wherever I wanted to go. I also de-

cided to become affiliated with the mental hospital, and had to start thinking about a car and bags and so forth to move some of my things out there.

B. In the midst of her troubles, Miss B. begins to get to where she wants to go with her analyst, and to settle down to steady analytic sessions with him. She also makes arrangements to take her driving test. She also packs her bags and so forth and starts to take the short summer vacation to which she has been looking forward.

C. Herbert Dawes finally gets to where he is (unconsciously) going: He kills his wife, and gets in his car and drives to his shop to try on a suit which he had made for a (prominent) woman. This suit (made for an "old bag") has all the feminine accouterments and so forth which he has always unconsciously wanted to wear.

*"I find that I have to do everything myself as she is scared and helpless, and I make a note of this fact."*

A. I found (of course) that I could not rely on my analyst to make my decisions, but that I had to make them all myself. I made a mental note of this fact. Also: In getting my things to the mental hospital, I found that the friends on whom I had relied to help me actually were too busy or had excuses for not doing so. Consequently I had to arrange for all the moving myself.

B. Miss B. found that she had to make her own decisions, rather than rely on help from her analyst or her friends. She also found, when she came to take her driving test, that she had not been taught to do certain things which should have been included in her teaching, and that she therefore had to overcome her scared and helpless feeling, summon up her nerve, and arrange, on a thoroughly impromptu basis, to do everything herself.

C. Herbert Dawes found that, being scared and helpless, he had to summon up his last reserve of strength and do everything himself—including murdering his wife and daring to start a complete identification with his feminine component.

*"I eventually park the car and take the bags into a department store."*

A. I eventually got my things packed, moved them to the hospital, and parked them and myself at this huge institution, which is a veritable department store in size as compared to other mental hospitals.

B. Miss B., getting set with her analyst, took herself and her bags for a vacation in a very large resort.

C. Herbert Dawes was eventually forced by the police to park his car and had to take himself and his woman's clothes off to jail.

Here ends the dream of Eisenbud's analysand. Out of this dream material, with the help of associational material of the patient (which I did not even bother to use in my analyses), and with the aid of interpretations which are frequently far less manifest and far more far-fetched than those I have just employed, Eisenbud builds what is on the face of it fairly convincing "telepathic" connections between the elements of the dream and the emotional and ideational aspects of his own life. But the point is—and the interested reader may compare for himself our two sets of interpretations—my interpretations seem to be quite as convincing, and in some respects more so, than Eisenbud's. Or, in other words, if the coincidences between Eisenbud's interpretations and the dream material of his analysand are brought forth as indisputable proof of the "telepathic" quality of his patient's dream, then the evidence seems just as convincing that this same patient, in this very same dream, was able "telepathically" to see what was going on in my mind and my life in October 1947, what was happening to Miss B. in July 1948, and what Stuart Engstrand was inventing for the fictional Herbert Dawes some time prior to 1947. Since the patient's dream, to judge from Eisenbud's account, seems to have occurred during the first week in November 1947, and presumably was relevant to her own life and analysis during the preceding weeks, as well as ("telepathically") to Eisenbud's emotional and ideational concerns, two alternative conclusions seem to be justifiable here: Either (a) this patient has been a partner to the most stupendous, colossal, miraculous quadruple-threat telepathic phenomenon of all time; or (b) very likely no telepathy at all has occurred here, and none, certainly, has been scientifically established.

Hypothesis "a" is even more unlikely than I have thus far made it sound for the simple reason that the three "telepathic" sequences which I deliberately read into the dream of Eisenbud's patient are but three of an almost infinite number of other sequences, involving both real and fictional characters, which I *also* could have linked "telepathically" with this dream, had I the time.

and inclination to do so. The interested reader, in fact, as a sort of exercise in analytic interpretation, can easily, I am sure, find several cases within his own ken—and particularly his own case, since he knows that best—which may be dealt with in the manner I have dealt here with my three illustrative cases; and, using the very same dream of Eisenbud's patient, he will have little trouble, I dare say, making the sought-for "telepathic" connections.

I may say, with Eisenbud, that just as he has corroborating statements from various associates to show that the coincidences between his affairs and the dream material of his analysis actually occurred, so do I have witnesses, including Miss B. and the various people mentioned in my foregoing analyses, who are willing to attest to the coincidences between the given dream material and the facts of my life in October 1947 and of Miss B.'s affairs in July 1948. As for the coincidences relating to Herbert Dawes, they are available for all to read in Stuart Engstrand's *The Sling and the Arrow*.

Enough is enough; so I shall end right here. Eisenbud, I am certain, will be entirely unconvinced by my present critique of his methods, just as he was previously unconvinced of my past analysis of his telepathic "findings." He will probably continue to work on the assumption, as he tells us with amazing frankness in his latest article, that "the problem of parapsychological research today is in large measure a promotional one; and, in my corner of the field, I have found it necessary to utilize, within the bounds of absolute clinical veracity, whatever merchandising techniques I have thought best adapted to get my goods moving. Where I felt it advisable to shock, I have shocked, and where I thought a little cajolery would do the trick, I have shamelessly cajoled." (Ref. 1, p. 130.) Intent as he is on "proving" at all costs, and with a minimal adherence to scientific methodology, that telepathy exists, Eisenbud's latest paper on "telepathy" in psychoanalysis will not, I fear, be his last. But I sincerely hope, for the sake of the infinitely more important psychological issues and researches now at stake, that this will be mine.

56 Park Avenue  
New York 16, N. Y.

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2. Ellis, Albert: Telepathy and psychoanalysis: a critique of recent "findings." *PSYCHIAT. QUART.*, 21:607-659, 1947.

(EDITOR'S NOTE:—Dr. Eisenbud has declined to reply to this paper. He has asked *THE PSYCHIATRIC QUARTERLY* to inform its readers that, without having seen Dr. Ellis' article and with information only as to its topic and not as to its contents, he has declined in advance to answer it.)

# A PSYCHOPATHOLOGICAL CLASSIFICATION OF SCHIZOPHRENIA\*

BY DAVID P. AUSUBEL, M. D.

## I. INTRODUCTION

The aim of this paper is to evolve a psychopathological classification of schizophrenia based on the common clinical differentiation into "constitutional" and "environmental" types. Since the clinical contrast between these two types of cases is so vividly a part of the everyday experience of every psychiatric hospital, the classification will be advanced on theoretical grounds alone without reference to actual case material.

Recent experience with combat-engendered schizophrenic reactions has tended to consolidate an old and long-standing clinical impression that there are essentially two different types of schizophrenia. Strecker and Ebaugh state, "It is important to distinguish between what might be termed a constitutional shut-in type, and one which is wholly or in part the product of environment. . . . The latter is a feasible defense against definitely inimical reality."

In the first or classical form of schizophrenia, the psychosis is merely the culmination or end result of the natural evolution of the pre-schizophrenic personality: It is the almost invariable and insidious outcome of the continued existence of this type of personality make-up—or, at any rate, if a mental disorder occurs in such a personality, no other type of psychotic reaction seems conceivable. Most commonly these cases fall into the simple or hebephrenic varieties. On the other hand, in an individual not endowed with the pre-schizophrenic personality, another type of schizophrenic reaction may occur which is, more or less, a paroxysmal, abortive attempt at adjustment upon confrontation with overwhelming environmental demands. Such an individual has previously adopted normal or other abnormal but non-schizophrenic techniques of adjustment and actually and potentially has a better adjustive capacity than the classical type. This second variety of reaction occurs later in life, begins more acutely, is more exogenous in origin and runs a more benign course. There is often a strong affective component present, as in the catatonic variety, or various compensatory paranoid trends. This reaction is not a

\*Read at the New York State Interhospital Conference, Syracuse Psychopathic Hospital, April 27, 1948.

cumulative or well-nigh inevitable result of a pre-disposing personality disorder, but a transitory, or sometimes permanent, incident in the adjustment of an essentially non-schizophrenic reaction type to the vicissitudes of life. From this point on, it will be more convenient to refer to the first or classical type of schizophrenia as *evolutionary*, and the second as *reactive*.

Although this differentiation into two essential types was made clinically many years ago, and is accepted today by many clinicians, it has never been practically applied to the actual classification of the various types of schizophrenia.\* The reason is not too difficult to understand; the differentiation raised too many psychopathological problems for which answers were not yet readily available. Are these two forms of schizophrenia related in their primary mechanisms, or are they two different diseases? If they are related, where is the psychopathological point of departure? How are we to explain the presence of manic-depressive or paranoid features in dementia praecox, and schizophrenic features in other reaction types? Can schizophrenic reactions occur in psychopathic personalities and psychoneurotics? If the pre-schizophrenic personality looms so large in the causation of one type, how can it be of indifferent importance in the other type, and yet both remain in the same diagnostic category? If introversion is not an essential pre-disposing trait, what then is the primary psychopathological mechanism? These problems left unanswered, it seemed more expedient to retain the symptomatic Kraepelinian classification evolved in the descriptive era of psychiatry, despite its obvious inadequacy, than to experiment with an etiological or a pathogenetic classification which has always been acknowledged as the ultimate aim in all medical nosologic schemes. At the present time, however, enough is known about the structure and development of both normal and schizophrenic personalities to attempt a classification according to psychopathology, based on this obvious clinical dividing line.

The psychobiological school left room for both types in its definition of schizophrenia. On the one hand, it regarded the schizophrenic process as a "reaction technique to life situations which threaten disaster to the personality"; on the other hand, it recog-

\*Some authors use the terms "acute" and "chronic"; but this is intended as a subsidiary designation and does not make clear whether mode of onset or course of development is meant. Sullivan distinguishes between an insidious type which is malignant and an episodic type which is benign.

nized the process as "the end result of an accumulation of faulty habits of reaction." This formulation, however, was so all-inclusive and general in nature as to be ambiguous with respect to psychopathology, since the same description could be applied with equal validity to the development of any psychosis. The psychopathological basis for the differentiation of the two types was still left unexplained. Instead, an attack was made on the psychopathology of the evolutionary type; and, while the chasm between the two types was formally recognized, attention was almost exclusively directed to the pre-psychotic personality in the evolutionary form of the disease. Along with Bleuler and Kretschmer, the Jungian concept of introversion\* was emphasized by the psychobiologists as the most important factor favoring the development of schizophrenia. Thus, Strecker, expressing the psychobiological viewpoint, conceives of schizophrenia as a compensatory flight into unreality aiming to overcome the discrepancy between normal ambition and poor performance as conditioned by "a dangerously introverted personality poorly equipped to come to grips with reality." Bleuler and Hoffman also emphasized the importance of a "schizophrenic thought process" (e. g., "the archaic and primitive thinking" of Storch), in addition to the presence of a predisposing schizoid personality. But it might be argued that this aspect of the pre-psychotic personality is an early symptom of the disease rather than evidence of predisposition.

It might also be noted that, so far, the psychobiological formulation has mainly considered the schizoid personality's relation to reality, and has regarded the ego-structure itself as essentially normal insofar as motivation, and the maturation of the ego-demands are concerned. The ego-structure is conceived of as being strong; and the individual is supposed to suffer keenly from a sense of frustration that goes with the thwarted goal of self-realization—and hence is prone to seek relief in a world of fantasy. This statement, although applied to the schizoid personality in general, would only hold true if a person were also motivationally adequate, or, in other words, if he were a candidate for one type—the *reactive* and not *evolutionary* form of schizophrenia.

\*Numerous attempts were made (Kunkel, Farrar, Kretschmer) to classify various types of pre-schizophrenic or schizoid personalities; but these resolved themselves into descriptive enumeration, shedding little light on the underlying mechanisms.

It is true that Farrar's classification of "shut in" personalities included two types that are obviously immature from a motivational standpoint (the "backward" and the "juvenile") and that Sadler identified this same characteristic in schizoid youths; but on the other hand this characteristic is not clearly separated from the factor of introversion, or related psychopathologically to the differentiation of the two main types. It is also evident that an individual will not suffer unduly from the frustration of his "normal adult goals" if his goals have not matured to the adult level in the first place. Therefore, to understand the psychopathological development of the schizophrenic process, it is necessary to consider more than simply the inward or outward direction of emotional energy in relation to the environment. It is also necessary to determine the level of ego-maturation to which the emotional energy is bound since (a) extroverts also fall prey to the disease; (b) the factor of introversion sheds no light on the motivational adequacy and maturity of the individual, which is of prime etiological significance; and (c) introverts also develop the *reactive* form of schizophrenia in addition to the *evolutionary* type.

This aspect of the schizophrenic process—the role of ego-maturation—has naturally received considerable attention from the psychoanalytic school. In accordance with general psychoanalytic theory, schizophrenia involves a regression to deeply infantile (narcissistic) fixation points in psychosexual development. In the evolutionary type of schizophrenia, the factor of fixation as interfering with the normal maturation of the ego, could be conceived of as the more important etiological element; whereas, in the reactive type, regression, following failure of adjustment to a current situation, is the more crucial mechanism. Depth of regression toward these fixation points is considered the main criterion for differentiation between the neuroses and the psychoses. The psychoanalytic view of the causation of the schizophrenic process is, of course, subject to the general criticism that psychosexual development is by no means co-extensive with ego development, and in any event does not follow a rigid predetermined pattern. In addition, (a) the role of introversion is not clearly delineated; (b) a psychopathological differentiation of the two types is not made except as regards the relative importance of fixation and regression; and (c) depth of regression is not a good clinical index of

the seriousness of a schizophrenic process, since, frequently, the patient showing the most regression makes the best recovery. More important than depth of regression is the original pre-psychotic level of ego-maturation and the significance of the regressive process in relation to the ego-structure. These points will be discussed later at greater length under their appropriate headings.

Thus, on the one hand, the psychobiological approach has elevated the factor of introversion to a position of unwarranted pre-eminence in the causation of schizophrenia by only taking cognizance of the medium in which the individual is attempting to gratify his ego-demands, without examining their intensity or adequacy; while, on the other hand, the psychoanalytic approach swerved to the opposite extreme.

In order to evolve a psychopathological formulation of schizophrenia which will explain the occurrence of the reactive form in both introverted and extroverted persons, and the evolutionary form in introverted individuals only, it will be necessary first to consider fully the relative contributions of these two essentially independent and crucial etiological elements—introversion and motivational inadequacy. The latter factor will be considered in the light of current concepts regarding the development and maturation of the ego.\*

## II. THE DYNAMICS OF EGO-DEVELOPMENT

The development of the ego can be divided into two main stages: formulation and maturation. Under the first heading we must consider the origin and evolution of the concept of self, and the factors entering into the inner determination of its magnitude and relative importance. The stage of maturation, on the other hand, covers the changes which this formulated ego must undergo in its transition from infantile to adult patterns. Related to the question of motivation, it is apparent that, in the first stage, the magnitude of the ego-demands will be set; and that, in the second stage, their maturity and adequacy will be determined.

The concept of self is first differentiated out of more inclusive concepts in which the notion of self blends indistinguishably with other objects and persons in the environment. In the pre-verbal stage, the concept exists purely in perceptual and functional terms.

\*Kasanin and French have suggested that an acute schizophrenic process may represent an abortive episode in reaction to adjustive difficulties found in a transitional phase of development.

Then, finally, objects and activities acquire the quality of "belongingness" out of which the abstraction of self-hood is derived. Partly because of the original vagueness surrounding the existential limitations of self, but more particularly because the infant's universe seems so "completely subservient in such all important matters as food, warmth and care," does the original conception of self become molded in narcissistic,\* omnipotent; and solipsistic terms. This infantile egoism is further strengthened by the normal display of parental adulation attending various phases of developmental accomplishment. However, this grandiose conception of self does not continue to develop unchecked. Before long, the infant becomes aware of his executive helplessness and dependency in dealing with reality so as to satisfy his needs.

This inevitable acceptance of a position of dependence on his parents for purposes of ego-gratification lays the basis for his subsequent identification with them, which mechanism, in turn, leads to progressive devaluation of the narcissistic ego. The process of devaluation proceeds along three different lines.

(a) Acceptance of parental discipline and training. The resistance offered by natural egoism to this training is responsible for negativism, while complete rejection of the same training results in the agenesis of conscience, the defect underlying the aggressive, antisocial psychopath.

(b) Satellization, or identification with the parents as such with subsequent submergence of the child's own individuality.

(c) Identification with, or introjection of, the parents' goals (beginning of the "ego-ideal").

Ego-formulation is thus a process of narcissistic valuation subsequently modified and devalued by the factor of dependency. If this devaluation does not take place, either because of parental overvaluation of the child, or as the result of a compensatory reaction to parental rejection, a "hypertrophy" of the ego and the ego-demands occurs which creates a predisposition toward the development of anxiety states, and of various substitutive, rationalizing, and escape mechanisms in the event of the very probable frustration of the hypertrophied ego-demands.

\*In this article, this term is used as a *quantitative* expression indicative of the infantile magnitude of ego-valuation rather than in the usual qualitative sense denoting the inward direction of emotional energy, or the self as the exclusive object of erotic interest. In other words, *narcissism* is used synonymously with the more inclusive concept of infantile egoism rather than as descriptive of an infantile level of erotic development.

The child's dependence on his parents, however, has more far-reaching consequences than the mere dilution of his egoism. The inability of a child to deal directly with his environment in satisfying his wants also determines the *nature* and *adequacy* of his ego-demands and goal-seeking patterns. Hence arises the necessity for maturation of the ego, which is essentially a process whereby childish goals and goal-seeking patterns are transmuted into their adult counterparts. The keynote of this maturational process is an emancipation from the attitude of dependence on parents and parental surrogates. It is the dependency situation which determines the differential characteristics of infantile and adult goal patterns. Because of it, the child's attitude toward life must necessarily be hedonistic. He thinks in terms of short-term, immediate pleasures rather than in terms of long-range planning. His social attitude is more irresponsible than an adult's. He is less willing to accept the consequences of his actions, and his emotional response to disappointments is more uninhibited. He is more obdurate about compromising with the inevitable; and, being less responsive to the demands of reality, he is freer to indulge in fantasy-thinking.

It should be noted, however, that whereas originally the introduction of the attitude of dependency has the effect of diminishing the magnitude of the ego-demands, subsequent emancipation from this attitude does not result in a restitution of original ego-magnitude, but rather determines the ego-demands' direction and adequacy. The question of magnitude is more or less settled before maturation begins in earnest. The hypertrophied ego is pressed to undergo maturation like any other ego and, in fact, usually does, since the tendency toward self-assertion facilitates the process. An individual with such an ego ends up after maturation with exaggerated ego-demands, which, however, are motivationally mature and adequate; if this same individual does not mature adequately, he displays primary narcissism. Conversely, individuals with relatively modest ego-demands are more susceptible to maturational failure, since they resist dependency less. Thus, the over-indulged, overprotected, and dominated child, or the dependent child who over-identifies with his parents, finds great difficulty in making a successful transition between infantile and adult levels of motivational adequacy. Although this formal transition takes place under the impact of the new adjustive demands placed on

the individual during the adolescent period, its success is predicated upon the training for independence and responsibility inculcated during the pre-adolescent era. (See Table 1.)

Table 1. The Dynamics of Ego-Development in Relation to Predisposition to Mental Disease

Stages in ego-development	Developmental consequences to personality structure		Predisposition by developmental fail- ure to following mental disorders
	Normally determines	Agenesis results in	
I. <i>Formulation</i>			
1. Valuation in nar- cissistic terms			
2. Devaluation by the factor of de- pendency as a re- sult of identifica- tion with:			
(a) parental dis- cipline	Development of conscience	Lack of con- science and neg- ativism	Aggressive antisocial psychopathy
(b) parents <i>per se</i> (satelliza- tion)	Normal magni- tude of ego-de- mands	Ego-hyper- trophy	{ 1. Anxiety states 2. Paranoid conditions 3. Reactive schizo- phrenia
(c) parental goals	Ego-ideal		
II. <i>Maturation</i>			
of goals and goal- seeking patterns	Motivational maturity and adequacy	Motivational immaturity and inadequacy	1. Immature and in- adequate psychop- athy (in extro- verts)  2. Evolutionary schiz- ophrenia (in in- troverts)

### III. THE IMPORTANCE OF INTROVERSION

"Introversion" is one of the most abused and overworked concepts in the field of psychiatry. By many persons, it is used as if it were synonymous with "schizoid," "retreat from reality," and "narcissism." Historically, we have witnessed its overvaluation as a predisposing factor in schizophrenia. Actually, although the introvert is constantly forced to apologize for his existence, introversion is an entirely normal trait, and one of the two possible

normal emotional relationships of the individual with reality. Instead of direct emotional participation, the introvert's emotional contact with reality is realized indirectly through the medium of symbols and intellectualization. Introversion becomes a pathological escape from real life only when the mediating thought processes and symbols become stripped of emotional content and become ends in themselves. It is true that the introvert stands on more tenuous ground than the extrovert because his participation in reality is one step removed, and is, hence, more vulnerable to artificial separation from its confines. An introvert thus finds it easier to indulge in day-dreaming and fantasy-thinking. Introversion is also more common in children because of their more limited experiences with their environments and their lesser degree of responsibility toward environment. Its original development is probably the outcome of several factors: constitutional; early distasteful experience with reality "in the raw," setting up the need for "cushioning" in sensitive children; and a need for a part-time escape from reality.

Thus, introversion while certainly not pathological in itself (especially in a motivationally adequate individual) is undoubtedly a pre-disposing factor in the ultimate emotional withdrawal from reality that must occur in schizophrenia. This latter mechanism is an essential part of the schizophrenic process. Motivational inadequacy in itself can account for the apathy and inappropriateness of affect, but not for the complete rejection of hedonistic gratification in reality—a gratification which the inadequate psychopath partakes of so freely. The introverted motivationally inadequate individual finally withdraws emotionally from reality not because of an overwhelming sense of failure following the frustration of normally motivated drives (for he has no such sense of failure), but because he "concludes" that reality is an unsuitable medium for the gratification of his immature ego-demands, and forsakes it for the obvious superiority of the world of fantasy with whose enchantments he has been progressively flirting.

In the sense that this rejection of reality (as well as advanced introversion) is only a compensatory mechanism permitting adequate gratification of immature ego-demands, motivational inadequacy can be regarded as a more fundamental pathological determinant of schizophrenia than introversion, since it constitutes a broader and more general disease process—which results in

schizophrenia when combined with introversion, and produces an inadequate psychopath when co-existent with extroversion. This complete break with reality "lessens the censorship of social criteria and inhibition," and hence grants complete freedom for the gratification in fantasy of infantile longings (which may or may not be regressive, depending on the pre-psychotic level of ego-maturation). On the other hand, the inadequate psychopath, who fulfills his immature longings within the framework of reality, must employ more rationalization to gain the same objective of a sufficiently impaired self-critical faculty to dispel all guilt-feelings.

#### IV. A PSYCHOPATHOLOGICAL CLASSIFICATION OF SCHIZOPHRENIA

The dynamics of ego-development and the nature of introversion have been discussed in some detail to provide the necessary background for a psychopathological classification of schizophrenia which respects its natural clinical occurrence in two distinct forms (evolutionary and reactive) but yet—by inquiring into the underlying mechanisms of each—seeks to transcend a mere descriptive enumeration of symptoms. Defined in psychopathological terms broad enough to include both types, schizophrenia must be considered an abnormal adjustment to life situations that involves emotional withdrawal, both (a) from adult ego-demands and (b) from reality (with a compensatory attempt to gratify infantile longings in fantasy). In this sense, schizophrenia is conceived of phenomenologically as a clinical reaction reflecting two component pathological mechanisms, either of which may develop gradually or paroxysmally.

In the evolutionary type, both mechanisms develop gradually in the course of personality growth; and the final insidious appearance of the disease is but the culmination of their evolution. The primary mechanism involves a motivational immaturity and inadequacy, due to a maturational defect in ego-development, as a result of which childhood goals and goal-seeking patterns fail to evolve into their adult counterparts. Co-existent with this motivational immaturity is an introversion of personality which is partly an independent character trait, and partly a compensatory mechanism permitting transitory flights into fantasy. This pre-existing introversion facilitates the final retreat from real life, because, all along, the pre-schizophrenic individual maintains only

an indirect emotional relationship to reality, cushioned by introspective intellectualization.

Handicapped by this personality make-up—having no stake in the adult world of reality motivations, and little opportunity for gratification of infantile desires (as long as he is required to adjust according to adult standards)—the individual gradually withdraws whatever emotional energy he has invested in adult goals and in reality. As already suggested, some precipitating event eventually occurs, often trifling and insignificant enough in itself, which convinces him that adult motivations and reality-living represent losing propositions; and that he would fare better by dropping all pretense of adult reality-adjustment, and frankly expressing his true desires in fantasy.

This view—which considers both the original immaturity in goal structure as well as introversion—takes issue with the psychobiological emphasis on introversion alone as the main predisposing factor in schizophrenia, and with the further psychobiological implication that the schizophrenic, pre-psychotically, is motivationally adequate, and only reverts to infantile techniques as a form of compensation for the frustration inevitably predetermined by his extreme introversion. (This latter interpretation holds true only for those cases of *reactive* schizophrenia occurring in introverted, motivationally mature individuals.)

The present view also takes issue with the psychoanalytic tendency to ignore the factor of introversion, and to stress the importance of narcissism as the mechanism *par excellence* in the generation of schizophrenic symptoms. As already set forth, narcissism harks back to the earlier stage of ego-formulation, in which natural egoism is insufficiently devalued; it is not a consequence of failure of ego-maturation. In the evolutionary type of schizophrenia, there is little of the regression so commonly referred to, since regression presupposes the original attainment of a higher level of goal-maturation which simply does not prevail in this type. There is only a *spurious* regression which merely represents the release of immature drives when the repressive influence of reality-censorship is removed. True regression appears only in the reactive form of the disease.

Standing at the opposite clinical and psychopathological pole from the evolutionary type, is the paroxysmal reactive form of schizophrenia. In this reaction, the individual exhibits pre-psy-

chotically an extroverted personality as well as motivational maturity. However, there is usually some degree of ego-hypertrophy resulting from insufficient devaluation of the solipsistic ego-formulation which later undergoes normal maturation. This person's exaggerated ego-demands are perhaps previously satisfied by a benevolent environment; or, vicariously, by rationalization, or, perhaps, even left unsatisfied as part of an anxiety neurosis. Then suddenly the environment ceases to remain benevolent and rationalizations break down, or the chronic deflation of self-esteem becomes insufferable. The previous satisfactory or non-schizophrenic technique of adjustment collapses, and a *reactive* schizophrenic process may develop as a sudden solution for the adjustive crisis brought about by the frustration of essentially mature, but exaggerated expectations of life. This paroxysmal reaction requires an abrupt withdrawal of emotional energy from reality, and an abrupt regressive dematuration of the ego-demands to the stage of infantile dependency. It is best exemplified by certain cases of catatonic dementia præcox.

Finally, there is an intermediate reactive form of schizophrenia in which only one of the two predisposing elements is present, and, hence, the other has to be developed paroxysmally. Here we have: (1) those cases of schizophrenia which develop in the excessively introverted personality who is motivationally adequate; and (2) the extroverted motivationally inadequate individual, otherwise known as the inadequate psychopath. The acuteness of onset and the relative prominence of exogenous factors, as well as the course and prognosis in these cases lies intermediately between that attributed to the two polar forms of schizophrenia already described.

As already explained, the original effect of the factor of dependency in ego-development is directed toward devaluation of the narcissistic ego, whereas afterward it serves to impede ego-maturation. It thus follows that a hypertrophied ego is less vulnerable to the possibility of maturational failure because of greater original (and persisting) resistance to this factor. Conversely, a hypertrophied ego is not usually found in a motivationally immature and inadequate individual. Therefore, primary narcissism, or the combination of ego-hypertrophy and motivational immaturity is a relatively rare clinical phenomenon. The introverted variety of this type is predisposed toward evolutionary

schizophrenia, and the extroverted variety toward the inadequate type of psychopathic personality and toward reactive schizophrenia.

A psychopathological classification of schizophrenia is summarized in Table 2.

Table 2. A Psychopathological Classification of Schizophrenia

Types	Predisposing traits and defects in personality structure
I. <i>Evolutionary</i>	The introverted, motivationally immature and inadequate personality.
II. <i>Reactive</i>	
A. <i>Intermediate</i>	1. The introverted, motivationally mature and adequate personality with ego-hypertrophy. 2. The extroverted, motivationally immature and inadequate personality (the inadequate psychopath).
B. <i>Paroxysmal</i>	The extroverted, motivationally mature and adequate personality with ego-hypertrophy.

This classification also has reference to the question of pre-schizophrenic personality. By referring to a given type of pre-psychotic personality, we are really stating that a given individual has a strong endogenous predisposition, because of personality structure, to develop just one particular type of psychosis, if he develops a psychosis at all. From the classification offered, therefore, it can be seen that the term "schizoid" should be applied only to those individuals prone to develop an evolutionary type of schizophrenia, that is, to persons who are both introverted and motivationally immature. Introversion alone does not inevitably predispose an individual to schizophrenia. Hence, it would be inaccurate to apply the term "schizoid" to an individual who later develops a reactive type of schizophrenia, because in this case there is just as good a possibility of his developing either a non-schizophrenic psychosis or a psychoneurosis.

It should hardly seem necessary at this point to justify the value of, or the necessity for, classification *per se* in psychiatry. Yet there is much talk heard nowadays about abolishing classification in favor of "just understanding the mechanisms underlying each particular case viewed in long section." This is in effect urging the adoption of that anarchy which would prevail in science following the abolition of general laws, and insisting on the construction of a separate and unique equation to describe the union of

each particular sodium atom with each particular chlorine atom to form a molecule of salt. At other times, classification is referred to as a burdensome process obstructing the understanding of case material, but still necessary for purposes of verbal and statistical convenience. This criticism, which should be reserved for outmoded classification, is unfortunately directed against classification in general. Here classification is made the scapegoat for the general theoretical chaos reigning in the field; for what else is classification if not a mirror of the state of clarity prevailing as regards the various concepts and their inter-relationships within a given science?

The aim of medical classification is to differentiate clinical syndromes by the differences in their respective underlying mechanisms. Classification, therefore, should aid rather than retard the understanding of a particular case, because the use of a specific diagnostic designation presupposes the perception of the basic mechanisms involved in contradistinction to all other pathological mechanisms. The use of a given diagnostic entity in this sense does not in the least interfere with the further description of the unique personal evolution of a case within a more general category.

#### V. SYMPTOMATOLOGICAL CONSIDERATIONS

At this point, it might be worth while to discuss briefly the interpretation of some of the leading symptoms of schizophrenia in the light of the foregoing psychopathological classification.

Simple schizophrenia contains all of the essential primary symptoms attributable to the two basic psychopathological mechanisms found in the *evolutionary* form of the disease. The pre-psychotic personality of the patient reveals a long history of motivational immaturity and inadequacy coupled with introversion. The emotional blunting, apathy, and disinterest in surroundings, together with the resulting personality and intellectual deterioration, are but the culmination of the process of emotional withdrawal from meager attachments to adult goals and reality. The lack of correlation between emotional expression and mental trend is only natural, since there is no longer any emotional identification with the ideational content that most normal people live by. What is finally achieved is a state of complete passivity and dependency characteristic of the earliest stages of ego-maturation. In this

connection, it may be noted that many simple (evolutionary) schizophrenics are able to make a partial adjustment to reality just as long as they remain within the protected environment of the institution.

All of the other symptoms of schizophrenia (except those excursions into fantasy referable to the infantile motivational level) are not basic to the primary psychopathological mechanisms, and are for the most part outgrowths of the ego-hypertrophy which is characteristic of most cases falling into the reactive group. Psychopathologically, these supplementary symptoms may be divided into two main categories: (1) Those which are indicative of other non-schizophrenic adjustive techniques (possibly tried before), and are directed more within the framework of reality; and (2) regressive expressions of narcissism, since here the de-maturation of the hypertrophic ego (otherwise directed into mature, socially-acceptable channels) results in the resurrection of the original solipsistic ego instead of merely the normally devalued immature ego present in the evolutionary type.

The simplest examples of the first type of supplementary symptoms are the hallucinations and delusions, which are referable to the paranoid reaction-tendency to negate frustration by distortion of the environment (rationalization and projection). These symptoms must be differentiated from their evolutionary schizophrenic counterparts—which are not purposeful distortions of reality, but simple psychological consequences of the greater vividness of the endogenously-derived, as compared to the external, sources of conscious data. Since the latter variety are not in the least referable to reality, they need not be at all consistent, systematic, or logical as the former ones are.

The most common examples of the second type of supplementary symptoms (regressive narcissism) are active catatonic negativism, and the hebephrenic ideas of rebirth, "eternality," omnipotence, and cosmic identification, which recapitulate the corresponding infantile elements of narcissistic solipsism as modified by the greater breadth of adult experience. (Catatonic hyper-suggestibility on the other hand is more indicative of extensive de-maturation and symbolic of complete passivity and dependence.) An actively negativistic catatonic schizophrenic, like a crossed, spoiled child, tries to destroy the objects and persons in his environment responsible for frustrating his aroused hypertrophic ego; whereas

the manic patient is seeking to negate frustration by ceaseless, directed activity, the success of which is internally assured by gross impairment of the self-critical faculty.

The rare cases of schizophrenia occurring in children are due to a more complete and malignant introversion and defect in ego-maturation, so that a break from reality, and from the chronologically expected level of motivational maturity, occurs prematurely.

## VI. SUMMARY AND CONCLUSIONS

A psychopathological classification of schizophrenia is offered which takes into account its clinical occurrence in two distinct forms, evolutionary and reactive. The main psychopathological mechanisms involved in schizophrenia are held to be severance of emotional identification from (a) adult ego-demands and (b) reality. In the evolutionary type the mechanisms are cumulative outgrowths of (1) a maturational defect in ego-development causing motivational immaturity and inadequacy and (2) a predisposing introversion. In the paroxysmal reactive form, both mechanisms develop precipitately. In the intermediate reactive form, only one of the two necessary mechanisms develops paroxysmally, the other being rooted in personality structure. Regressive narcissism, as symptomatic of reactive schizophrenia, is referable to ego-hypertrophy (a residual sign of insufficient devaluation in the earlier stage of ego-formulation), and is hence not fundamental to the basic defect in ego-maturation found in evolutionary schizophrenia. In the evolutionary form of the disease, reality is rejected in favor of fantasy, not because of a compensatory need to gratify normal ambitions whose frustration is predetermined by excessive introversion (since the latter ambitions are in fact non-existent), but because reality is recognized as an unsuitable medium for the gratification of immature and inadequate ego-demands.

What advantages does such a psychopathological classification have over the present symptomatic grouping? In the first place, it differentiates the two main clinical types psychopathologically and is descriptive of the essential underlying mechanisms with respect to such important factors as ego-development, introversion-extroversion ratio, relative prominence of endogenous and exogenous elements, and relative inevitability of occurrence. Second, it is more useful clinically since it also indicates acuteness of on-

set, probable course of development, the probability of other non-schizophrenic symptoms being superimposed on the clinical picture, and prognosis. The symptomatic classification has none of these advantages, and permits too much overlapping of types. Also, since the symptomatology in most cases is mixed, too much depends on the individual observer's choice of the outstanding symptom. Therefore, the symptomatic classification which ignores the obvious clinical differentiation into the two main types as well as the psychopathological basis for the same, and which is notoriously and unreliably variable in the hands of different observers (or even in the hands of the same observer) must of necessity be statistically invalid for studying and comparing cases as regards onset, course, prognosis, efficacy of a given type of therapy, and diagnostic criteria.

4211 Highland Avenue  
Brooklyn 24, N. Y.

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## ELECTRIC AND METRAZOL SHOCK TREATMENT DESPITE PHYSICAL CONTRAINDICATIONS

BY H. J. KLEINSCHMIDT, M. D., J. S. A. MILLER, M. D., M. H. ORENS, M. D.,  
AND LESTER COHEN, M. D.

There is a vast literature on the subject of complications and contraindications for convulsive shock treatment. A study of the publications, however, reveals that many of the authors have come to conflicting conclusions. One might be inclined to assume *a priori* that wide divergencies in opinion could hardly exist in a field where the same more-or-less-well-defined techniques are used and where conclusions should be based only upon objective clinical findings. But one must agree with Brain and Strauss<sup>1</sup> "that the introduction of any new form of treatment mobilizes great stores of emotion in both antagonists and protagonists." This would explain why similar clinical observations are interpreted so differently by different investigators. Those in favor of the treatment tend to minimize its risks and dangers, while its opponents emphasize the seriousness of possible complications and consider the list of contraindications, for electric shock treatment as well as metrazol, to be a long one (Kleinerman<sup>2</sup> and others).

While Jessner and Ryan<sup>3</sup> refused shock treatment to patients suffering from cardiovascular disease, acute infections, recent tuberculosis, as well as chronic lung disorders, severe thyrotoxicosis, intracranial disorders, and organic diseases of the central nervous system, and warned against treatment in cases with hypertension and spinal curvature, Moore<sup>4</sup> and Gallinek<sup>5</sup> found from their experiences that many patients exhibiting one or another of these physical conditions can be treated successfully and without mishap. Only two deaths occurred in Moore's material of over 2,000 cases, one as late as four weeks after a course of only three treatments—one grand mal and two petit mal seizures—in a patient with a severe cardiac condition, the other during the night after the first treatment which resulted only in three petit mal seizures. Autopsy revealed subarachnoid and petechial hemorrhages of the brain with marked venous congestion. Two hundred and thirty-eight cases with heart diseases—57 with myocardial disease, 25 with rheumatic heart disease, 21 with hypertensive cardiovascular disease, 21 with coronary disease, nine with proved infarcts, eight with branch bundle block, five with A-V block, 87 with various

cardiac disorders—were treated without any serious complications. One hundred and ninety patients with hypertension showed no ill effects; on the contrary, the hypertension improved in many cases.

Gallinek<sup>5</sup> successfully treated 18 patients of advanced age—up to 84 years. Straker<sup>6</sup> reports his experiences with two patients, suffering from neurologic conditions such as hemiplegia and aphasia, in addition to their psychosis, who were treated successfully with electric shock therapy without neurologic sequelae. Ziskind and Sommerfeld<sup>7</sup> treated a patient suffering from post-encephalitic parkinsonism with severe oculogyric crises, with five metrazol convulsions. The patient improved considerably, the crises were diminished, his mood became euphoric and he gained weight, while the rigidity remained unchanged.

Karliner,<sup>8</sup> in a recent paper, sums up his findings by stating: "Electric shock treatments are safe, and in most instances are without untoward effects. With proper evaluation of indications and contraindications, no permanent damage is produced in persons who undergo these treatments. . . . The possible complications, when compared with the therapeutic results, are trivial indeed."

It has also been noted that a patient with generalized arteriosclerosis and emphysema, who had to be taken off insulin coma treatment because of acute myocardial failure, showed no ill effects from 20 electric shock treatments, one of which was given the very day following the discontinuation of insulin treatment (Kleinschmidt<sup>9</sup>).

Jetter<sup>10</sup> reported the postmortem findings in three cases of death due to acute cardiac failure. Two of the three patients were over 60 and were known to have had advanced coronary sclerosis. The third, a man of 23, apparently healthy at the beginning of treatment, died 12 hours after the eighth electric shock treatment. Autopsy showed acute myocarditis, acute glomerulonephritis, edema of the lungs, hydrothorax, and ascites. Jetter emphasizes that the postmortem examination of these three cases did not reveal any pathological changes in the brain attributable to electric shock. He reports a mortality rate of 1.2 per thousand in 2,500 patients treated, while an investigation of 7,200 cases indicated a mortality rate for electric shock of only 0.5 per thousand, as compared with 1.0 for metrazol shock, and 6.0 for insulin coma treatment.

Although Bennett<sup>11</sup> has stressed repeatedly the absence of ill effects involved in the combination of curare with electric shock or metrazol in order to soften the convulsions, Riggs and Schlomer report instances of serious cardiac reactions from curare (intocostin) which could not be counteracted by intravenous injection of neostigmine. These authors suggest the use of the purified alkaloid, d-tubocurarine, to eliminate the danger of untoward reactions.

During a period of more than seven years, 825 patients of Hillside Hospital, Bellerose, N. Y., were treated with electric shock or metrazol. Although electric shock is the therapy of our choice in all cases of involutional simple or agitated depressions, manic-depressive episodes and acute catatonic schizophrenic episodes, we have given metrazol to patients who did not respond too well to a full course of electric shock. While it is generally agreed that there is no major difference in the therapeutic effects of these two methods, we, nevertheless, saw in some instances that individual patients who showed a less-than-satisfactory response to electric shock reacted more effectively to metrazol.

More than 5 per cent of the 825 patients treated with convulsive therapy were over 60 years of age. One hundred and nine of the total number of hospital admissions fell into the old-age group, ranging from 60 to 75 years old; 44 of these were treated with convulsive therapy, the oldest patient being 75, i. e., 40 per cent of the patients admitted in the old-age group were so treated. This demonstrates again the many indications for convulsive therapy during the senium.

## CASE REPORTS

### *Fatalities*

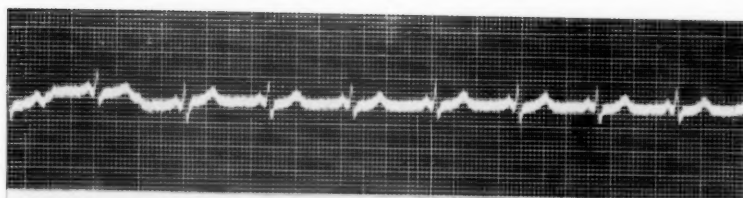
*Case 1.* Of all patients treated, four died while still in the hospital as patients, but only in one case was death the direct result of the electric shock treatment—and even this one not due to the electric shock itself. The patient, B. R. (No. 2693) was a 50-year-old man who was admitted to Hillside Hospital with a diagnosis of involutional psychosis, melancholia. After the fourth electric shock treatment, he complained of severe back pain. The x-ray showed a compression fracture of the body of the third thoracic vertebra. Since the patient had already shown some improve-

ment, therapy was discontinued. But in a short time he relapsed; and the therapy was resumed, now combined with curare (intocostarin) to prevent any further damage to the injured vertebra. The first six treatments in which curare was used were completely uneventful. The seventh, given in exactly the same way as the others, resulted in rather prolonged apnea. Artificial respiration was administered and prostigmine, 0.5 mg., was given intravenously. The patient started to breathe but remained unconscious and, in spite of repeated intravenous injections of prostigmine and later coramine, etc., died 14 hours after the shock treatment was given. The autopsy showed a fractured vertebra, but no visible brain damage.

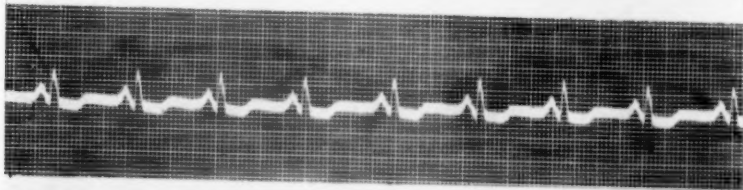
*Case 2.* The second death was that of L. L. (No. 3327), a 52-year-old man, a manic-depressive, in a depressive episode. Physical examination revealed a blood pressure of 178/110, and the electrocardiogram showed some evidence of myocardial infarction. The consultant internist saw no contraindication to electric shock treatment. The patient had 16 shocks with 11 grand mal reactions and seemed to be much improved. Two days after the last treatment he suddenly developed severe dyspnea with clinical evidence of an acute coronary occlusion, and he died within a few hours. There was no autopsy.

*Case 3.* The third death was that of G. B. (No. 2802), a 62-year-old man who was admitted with a diagnosis of involutional psychosis, melancholia. His main symptoms were those of severe hypochondriasis, associated with a marked, constant depression. Physical examination revealed a blood pressure of 220/110, with left ventricular enlargement, but no evidence of cardiac failure. He was seen by the consultant internist who recommended mercurhydrine, 2 cc. intramuscularly, for vasodilatation. The blood pressure dropped to 172/100, at which time the internist felt there was no contraindication for electric shock. In five days, the patient received nine treatments, with only two grand mals. Four days later he developed pneumonia, was transferred to Bellevue where he made a rapid recovery, and was then returned to Hillside Hospital. He seemed to be doing well until suddenly, six weeks after his last electric shock, he developed an acute cardiac accident. The electrocardiogram showed a definite anterior wall infarction, and he died within a few hours. No autopsy was performed.

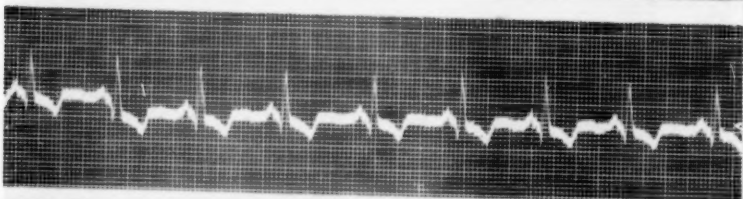
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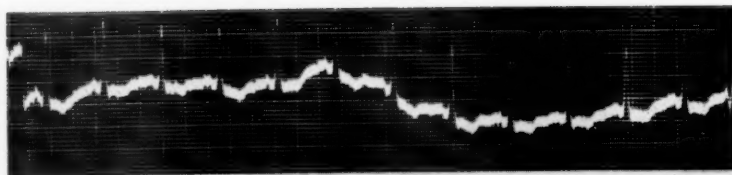


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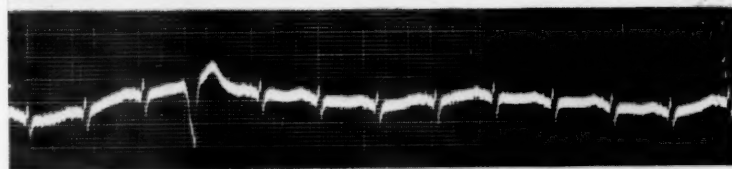


Case 2. Fatality

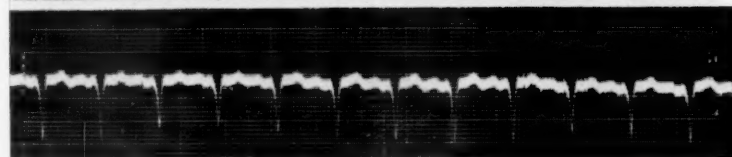
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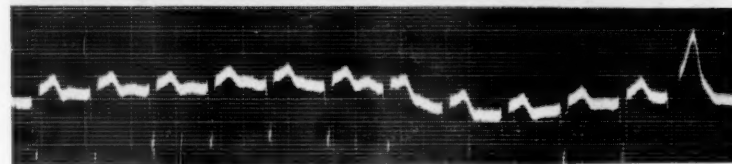
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Lead 4



Case 3. Fatality

*Case 4.* The fourth death was that of H. K. (No. 2796), a man of 50 who was admitted with a diagnosis of manic-depressive psychosis, depressive phase, and who committed suicide the day after the first electric shock treatment.

In contrast to these, are our experiences with a number of patients who were suffering from hypertension, myocardial damage of various degree, spinal curvature and pulmonary diseases, and who received electric shock and metrazol successfully and without any mishap or ill effect. Outstanding among these are the following six cases, the first of which had an active tuberculosis of the lungs, while the others showed definite evidence of severe myocardial damage, associated in some instances with advanced arteriosclerotic changes. All of these cases were considered poor risks for EST by our consultant internists. The mental condition of these patients, however, which became progressively impaired, in our opinion warranted the risk involved.

#### CASE REPORTS

##### *Successful Treatment Despite Findings Ordinarily Considered Definite Contraindications*

*Case 5.* M. S. (No. 2715), a 38-year-old physician, was admitted on May 13, 1946, with a severe depression. He had attempted suicide by ingesting about 12 grains of sodium seconal. On admission he expressed feelings of hopelessness, self-depreciation, and unworthiness, and he showed marked anxiety and agitation.

In the course of a routine examination while he was in the armed forces, a bilateral pulmonary tuberculosis had been discovered. The patient had been discharged from the service because of this disability, and had received collapse therapy of the left lung for the condition—with refilling at required intervals—until the time of his admission to Hillside. It was felt that the tuberculosis in the right lung did not warrant collapse treatment. As this patient was practically inaccessible to psychotherapy, and was extremely agitated and suicidal, it was deemed imperative to institute electric shock therapy, in spite of the presence of artificial pneumothorax on the left side with evidence of pulmonary tuberculosis on the right side.

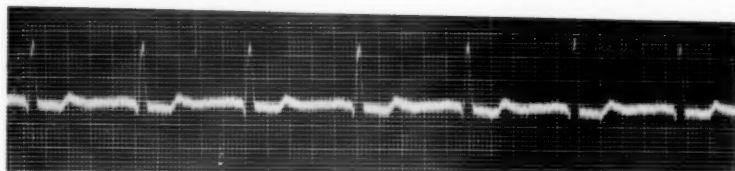
In all, the patient received 11 shocks, with eight grand mal seizures. His improvement began after the second major seizure, and after eight successful shocks his depression had cleared up en-

tirely. He then went into a mild hypomanic phase, with hyperactivity and cheerfulness. He planned to "take things easy" for a while, and to resume his practice only after a two-month vacation in the mountains. At the end of his vacation he was seen again. He appeared well-balanced; he was looking forward to taking up his work again, and he did not show undue concern over his physical illness. Five days before this patient's discharge on July 1, 1946, consultation with a phthisiologist revealed that the extensive shock therapy had had no deleterious effect on his pulmonary status. The sedimentation rate was six millimeters in the first hour, indicative not only of quiescence of his infection, but also that there had been no reactivation or extension of the process beyond his condition on admission.

*Case 6.* L. L. (No. 3101), a married man, aged 75, was admitted to Hillside Hospital on August 20, 1947, in a state of great agitation and apprehension, talking in a stereotyped manner of constipation and pains in his stomach. He complained of a burning sensation in the abdomen, and of a fear of impending death. He was convinced that he was suffering from a form of cancer which no doctor was able to detect, and that there was no help for him. His memory, both for recent and remote events, was intact, and retention and immediate recall seemed perfect. This patient had been well until seven years previously when he had undergone a prostate operation, following which he became very "worrisome," morose, and concerned over the fact that he continued to urinate frequently and that he did not recover completely from his prostate condition.

About four years before hospitalization he had been depressed, restless, and very concerned over his bowel movements. It was then that his cancerophobia became apparent. He made a suicidal attempt by opening gas jets, but he was discovered and sent to Brooklyn State Hospital where he stayed for about six months, making a "fair recovery." He returned home and remained fairly well for about two years, but continued to be rather morose and restless. About three months prior to his admission to Hillside one of his sons noticed that the patient was acting strangely at home, and his children had the feeling that he was again contemplating suicide. In spite of increased watchfulness on the part of his family, he succeeded in making a second suicide attempt by ingesting 12 sodium amytal capsules; and he was found the following morn-

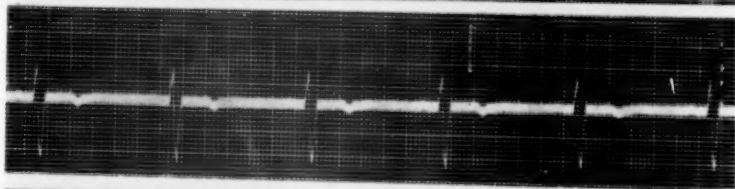
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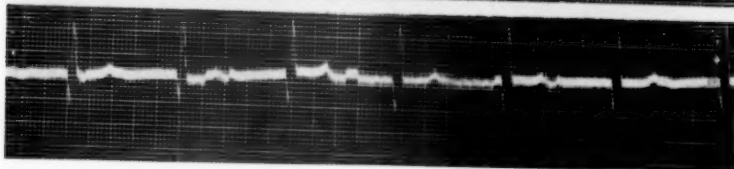
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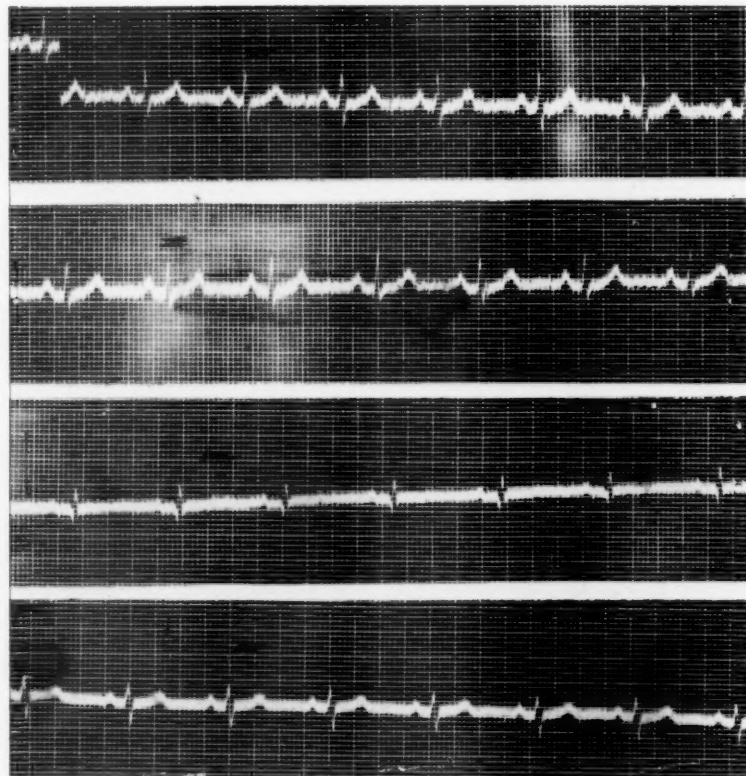
Case 6

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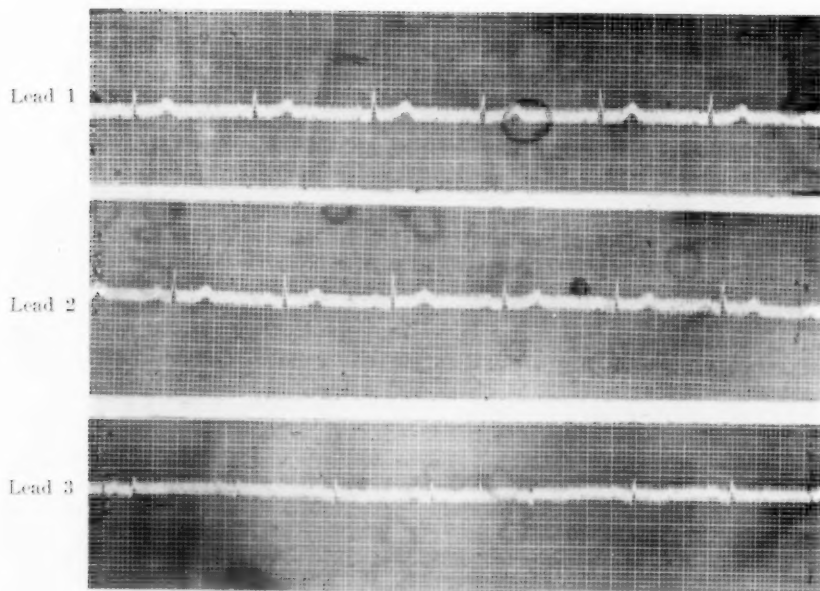
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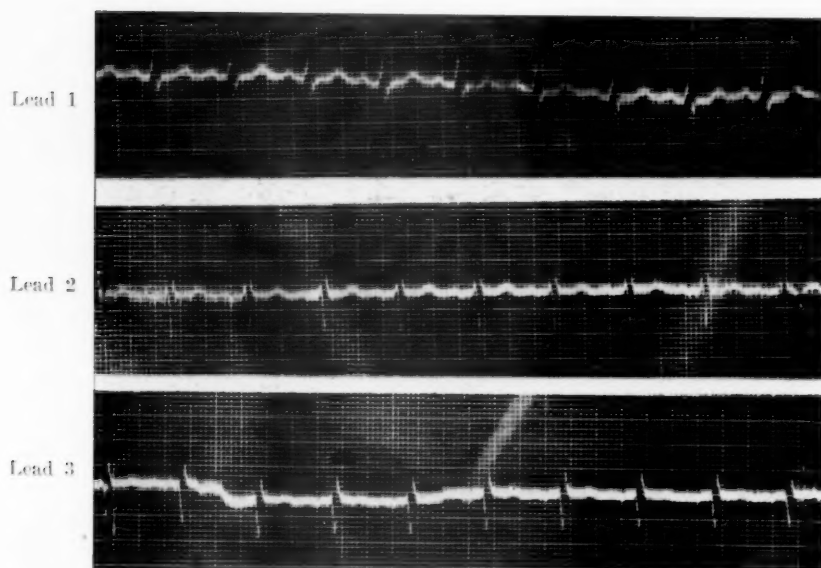
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Case 7

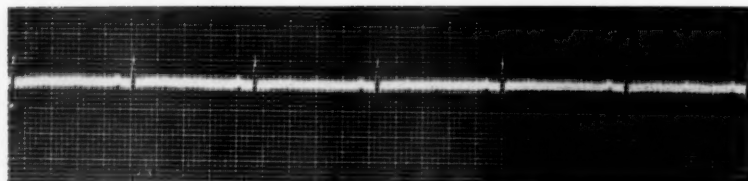


Case 8

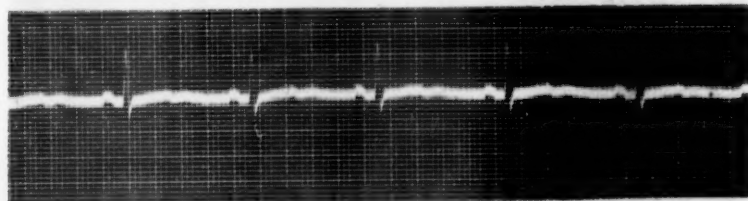


Case 9

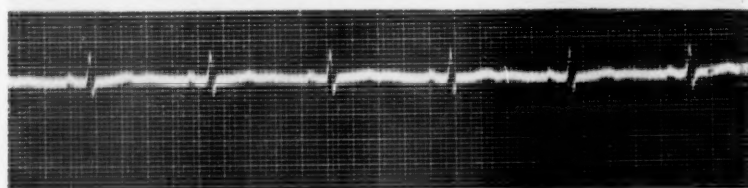
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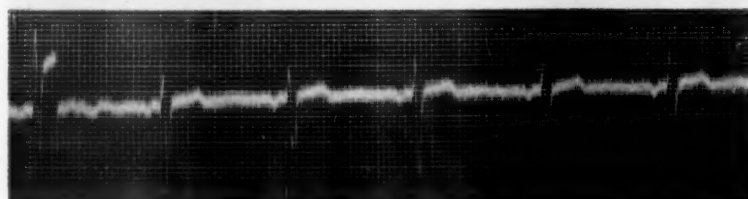
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Lead 3



Lead 4



Case 10

ing in deep coma. After having recovered from the effects of this attempt, he became extremely agitated and too difficult to manage at home. He was therefore sent to Kings County Hospital, where he remained for 10 days before being removed to Hillside.

Routine physical examination revealed normal physiological findings for his age. Repeated electrocardiograms revealed complete A-V block with ideo-ventricular rhythm, intraventricular conduction disturbances, and other findings of severe myocardial damage.

It was necessary to institute electric shock, and he had six grand mal seizures in 10 treatments, with the result that his depression cleared up entirely, his agitation disappeared, he began to eat, and made an excellent hospital adjustment. He rather enjoyed his hospital stay and was reluctant to leave. He was discharged on November 9, 1947 in a much-improved condition.

*Case 7.* L. T. (No. 3057), a 42-year-old married woman, was admitted on July 3, 1947 with the diagnosis of schizophrenia, catatonic type. The patient showed extremely bizarre behavior, walking in a very hesitating manner, stopping at every few steps, standing with closed eyes and twisting her mouth. During interviews, she would sit in her chair in a markedly rigid posture, again with closed eyes. Her speech was very manneristic and affected. The patient showed no insight and poor judgment.

Physical examination of the heart revealed a presystolic crescendo murmur with a thrill, the electrocardiogram showed right axis deviation and auricular involvement compatible with a diagnosis of mitral stenosis. In spite of the severe stenotic lesion, and keeping in mind the possibility of pulmonary infarction with apoplexy, it was deemed necessary to disregard this very evident severe cardiovalvular pathology and submit her to electric shock treatment because intensive psychotherapy over a period of five months had shown very little result. She had 17 grand mal seizures out of 25 electric shocks, combined with a full course of insulin coma therapy. The patient showed a marked and steady improvement shortly after this combined treatment was instituted, and her negativism and mutism disappeared. At the time of discharge she was completely symptom-free. She was discharged on April 10, 1948 as recovered.

*Case 8.* I. B. (No. 3102), a 70-year-old single woman, was admitted to Hillside on August 21, 1947 with a diagnosis of involu-

tional psychosis, melancholia. The patient was found to be extremely depressed and agitated, with ideas of sinfulness, hopelessness, and self-depreciation. There were also a number of somatic delusions. Her sensorium was intact, and there was no evidence of organic dementia. During the first two weeks of her stay at Hillside she continued to be agitated, refused food, and was uncooperative and completely inaccessible to psychotherapy.

Physical examination revealed a marked diminution in intensity of heart sounds with small peripheral pulse. The low voltage ECG confirmed the diagnosis of diffuse myocardial damage. Since it was felt that a prolonged state of agitation and starvation would place more strain on the heart than would a number of electric shocks, electric shock therapy was instituted. The patient had seven grand mal seizures in 11 treatments, with excellent results. Her delusional ideas of unworthiness and sinfulness, as well as her somatic delusions, disappeared, and her depression cleared up entirely. Her appetite returned to normal, and she became cooperative and pleasant. She was discharged on September 20, 1947 as recovered.

*Case 9.* W. D. (No. 3110), a 70-year-old widower, was admitted on August 26, 1947 with a diagnosis of manic-depressive psychosis, manic phase.

This patient was hypertensive. His blood pressure was 200/110; A-2 was markedly accentuated; and the electrocardiogram showed marked left axis deviation and myocardial changes of diffuse coronary sclerosis. In addition, bilateral inguinal herniae were present; and he was actively sick with a very severe bronchitis which necessitated sputum examination, both for organisms and for heart failure cells, with negative findings.

During his manic excitement the patient was almost completely unmanageable. It was therefore considered necessary to treat him with electric shock, in spite of the multiplicity of unfavorable physical findings and organic changes. He had one grand mal seizure and 10 minor seizures in 11 treatments and showed almost immediate marked improvement. There remained a mild lability of mood, and occasional irascibility which, however, decreased gradually. He was discharged on November 29, 1947 as recovered.

*Case 10.* J. P. (No. 2800), a 51-year-old man, was admitted on August 23, 1946 with a diagnosis of reactive depression.

His illness had begun in 1944 when he had a severe attack of coronary thrombosis for which he was ordered to bed for 13 weeks. Since that time, he had become increasingly depressed. He lost approximately 50 pounds, and became increasingly listless, withdrawing almost completely from his environment. His relationship to his wife became very strained. The depressive episode was his first.

Physical examination revealed the following findings: The ECG showed an iso-electric T-1, low voltage R-1, extremely low voltage T-2 and T-3; CF4 revealed cove-planed ST, all supporting suspicions of old anterior wall infarction. The ECG with rebreathing revealed no significant aggravation of these findings. Teleoroentgenology and fluoroscopy of the chest showed the heart to be normal in size and contour, and there was good cardiac contraction. Clinically, however, he impressed the physicians as being very ill; his breathing was disturbed, and during EST there was further aggravation of this symptom. He had, in all, 10 major seizures out of 15 electric shock treatments. He showed very good response to the treatment, and his depression cleared up entirely. He began to take a lively interest in his environment, gained a good deal of weight, began to sleep well, and felt optimistic about his future. He was discharged on December 14, 1946 as recovered.

## DISCUSSION

### *Fatalities*

*Case 1.* This man presented a not uncommon complication of convulsive treatment; namely, compression fracture of a vertebra. Because of his continued mental disability, electric shock had to be resumed and continued with the aid of curare (intocostrin) to prevent or mitigate further damage to the fractured vertebra. It is significant that under this combined treatment the patient was able to receive seven more treatments. The first six were uneventful. The seventh resulted in an inordinately long period of apnea which failed to respond in spite of specific counter-measures (prostigmine and coramine intravenously). The writers feel that respiratory paralysis in this instance was caused by the curare.

*Case 2.* Physical examination on admission, including the ECG, showed definite evidence of old posterior wall infarction. In addition, there were changes indicative of diffuse coronary sclerosis. At no time in this man's past history was there any mention of

heart disease. There were no symptoms suggestive of cardiac abnormality. In spite of the rather severe old ECG changes, no contraindications to electric shock therapy were entertained. This is further borne out by the fact that the patient was able to sustain 16 shocks without immediate ill effects following any treatment. The question can be raised as to whether his last and fatal coronary occlusion did not appear under coincidental circumstances, rather than as a result of electric shock treatment.

*Case 3.* This patient was admitted with severe hypertension, left ventricular enlargement, and all the symptomatology attendant to hypertension, in addition to his mental illness. Since the salt depletion regimen instituted for his hypertension caused a definite drop in blood pressure, it was felt at that time that electric shock might be employed, with a measure of safety. It is significant that his fatal coronary occlusion appeared six weeks after his last shock treatment; but in the interim he had developed pneumonia, for which he was transferred to Bellevue Hospital where he was treated for three weeks. Certainly, it would appear more justifiable to attribute his death to the effects of the pneumonia on his cardiovascular system, rather than to the shock treatment.

*Case 4.* This case was lost through suicide.

#### GENERAL REMARKS

Advanced age does not, in itself, present a contraindication to convulsive treatment, be it electric or metrazol shock. In the writers' fatalities, the ages varied as follows: 50, 52, 62. Among those successfully treated in spite of very obvious physical defects were patients as old as 75. In all, 44 patients above the age of 60 were treated successfully with electric shock or metrazol; six of these were 70 or older.

Out of 825 patients, six are reported (Cases 5 to 10) with physical findings ordinarily considered definite contraindications for convulsive therapy. No fatality occurred in this group. On the other hand, four fatalities are reported (Cases 1 to 4) among patients with similar physical disabilities; and it is shown that in no instance was the fatality directly attributable to the shock therapy.

The writers feel that in all cases where the mental state might ultimately lead to a fatal result—be it through suicide in a depression or through cardiac failure in prolonged manic excitement—it is justifiable to disregard even severe physical defects such as

those presented in the six successfully-treated cases. It then becomes a life-saving procedure to institute shock therapy.

#### SUMMARY AND CONCLUSIONS

In 825 patients treated with convulsive therapy over a period of seven years, four fatalities were encountered. One of the four cases was lost through suicide; in two, the death could not be directly attributed to the treatment; only one patient was lost as a direct result of electric shock treatment combined with curare. In this patient, all evidence seems to point to the curare, with its attendant respiratory paralysis, as the direct cause of death.

Forty-four patients in the old-age group were treated successfully with electric shock or metrazol, the oldest being 75. Six successfully-treated cases, with their physical findings on admission, have been reported in detail. Those cases, showing the usually accepted contraindications to convulsive therapy, have been presented in this report. The impression is gained that, in spite of such serious physical findings, convulsive therapy can be successfully instituted.

Hillside Hospital  
Bellerose, N. Y.

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## EDITORIAL COMMENT

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### TOPECTOMY—NEW LIGHT ON A STAB IN THE DARK

A group called the Columbia-Greystone Associates has completed one of the most extraordinary research projects in the history of medical science.

The central fact emerges: Eight "back ward" patients, of 24 upon whom an operative procedure was performed, improved and remained out of hospital more than one year.

The project concerns a brain operation called "topectomy" by those who devised it. The study was inspired by the fact that one of psychiatry's increasingly-employed physical procedures has been, literally as well as figuratively, a stab in the dark. Prefrontal lobotomy is not only an empirical, but also a blind, operation. Fred A. Mettler and Marcus A. Curry, commenting with temperate restraint on the status of lobotomy in 1947, remark that its rationale "still required clarification," that "under favorable circumstances the mortality rate was about 4 percent but it was not uncommon for the death rate to reach 10, 15 or even 20 percent," and that "while the occasional patient was well oriented, serious degradation occasionally followed" (when there was complete transection far rostral to the usual plane).

Noting that, despite these drawbacks, the practice of leucotomy continued to grow, Mettler and Curry further remark, in their report on the Columbia-Greystone project—which is quoted from extensively here—that profound changes in medical practice and theory are often brought about by influences outside the profession itself. Following World War II, public demand for more rapid and drastic treatment of the psychoses brought wide extension of "psychosurgery," first in the hospitals of the Veterans Administration, later in civilian mental institutions. It was under these circumstances that Columbia University and the New Jersey State Hospital at Greystone Park joined for such a comprehensive and ambitious piece of co-operative research as has seldom been seen outside war emergencies.

Headed by an anatomist and a psychiatrist, the Columbia-Greystone research enlisted authorities and experts in an extraordinarily wide field. In the official report of their work, *Problems of*

*the Human Frontal Lobe*, by Mettler, Curry and associates, an encyclopedic, detailed and yet beautifully stark, account of nearly every conceivable aspect of the brain operations undertaken—a report now in process of publication—eight workers join in presenting the chapter dealing with laboratory studies of the blood, five in the one on surgical procedure. So extensive were the records that the services of 10 secretaries were required for the report; the supervision of the 48 patients, the 24 who underwent the new brain operations and the 24 controls, involved a nursing director, five supervisors, 23 nurses and 12 psychiatric attendants. As Mettler and Curry observe: “As a co-ordinated attack upon problems in the field of neurology and psychiatry it [this study] was unique in method and magnitude. . .”

The operation of topectomy consists of the surgical removal of discrete parts of the cortex bilaterally, with the excised parts dissected out according to identified and recognized points of cerebral topography; in the Columbia-Greystone project, designation by areas on Brodmann's map was followed. Topectomy thus differs radically from lobotomy, in which blind cutting is “based on planes determined by [exterior] cranial landmarks,” and, in which, necessarily, the brain areas disconnected vary with individual patients' anatomical differences. This radical difference between the two operations may permit one tentative conclusion; the Columbia-Greystone research appears to have identified the cortical region which—when involved in the operation—seems responsible for whatever favorable results may follow prefrontal lobotomy.

From a procedural standpoint it may be stressed that the nature of the operation in each case was known only to the surgeon and to the anatomist until the recheck made three months post-operatively.

In their most exhaustive reports on the psychiatric aspects of the problem, Robert G. Heath, John J. Weber and Archie Crandell note that “many” of the 24 topectomy operations—those which did not involve areas later determined to be critical—were “ineffective.” The critical regions were identified as Brodmann's areas 9, 10 and 46; the ineffective operations on other areas totaled nine. Of the 14 patients whose operations implicated the critical Brodmann areas, nine were able to be at home, and eight were working at their pre-psychotic capacities a year after the

procedure. Counting only the schizophrenics operated on, five of 17 schizophrenic patients, or 30 per cent, were working at pre-illness capacity a year after their operations. Of the 17 schizophrenics undergoing operation, 10 had Brodmann areas 9, 10 and 46 removed; the five who improved were half of that 10, or 50 per cent of those with "effective" operations. The authors cite, for comparison, a six-year review of schizophrenic lobotomy cases indicating about 18 per cent of social recoveries, while Freeman and Watts, who are the recognized authorities on lobotomy, report similar results in about a third of their own patients. These figures contrast with 30 per cent of social recoveries in the total number of schizophrenics operated on at Greystone, and with 50 per cent of material improvement in those whose operations implicated the critical Brodmann areas.

If comparative results have the significance usually assigned to them, one could cite these figures as therapeutic justification for the Columbia-Greystone experiment. A later report on employment of topectomy for removal of the critical Brodmann areas appears to confirm this impression. Heath and J. Lawrence Pool, both of the Columbia-Greystone group, reported in May of last year\* on results, three months or more after operation on 15 private patients. They removed areas 9 and 10 only in this series; and they reported 10 of their 15 cases functioning at pre-psychotic capacities; while three more were able to remain outside institutions under supervision.

Good therapeutic results in a small group, however, may be one of the less significant accomplishments of the Columbia-Greystone research in the long-range progress of psychiatry. As Mettler and Curry set forth the objectives of the project, they were interested primarily in "information as to whether a less drastic and technically improved neurosurgical approach would produce results as satisfactory or perhaps even better than those obtained by lobotomy." While there is no desire here to jump to conclusions which the authors themselves carefully refrain from making, it seems obvious from the medical, neurological, psychological and psychiatric studies made that this primary objective has been attained. With all reservations which can be made because of the

\*Heath, Robert G., and Pool, J. Lawrence: Treatment of Psychoses with Bilateral Ablation of a Focal Area of the Frontal Cortex. Presented at the annual meeting of the American Psychosomatic Association at Atlantic City, N. J., May 1, 1948, published in *Psychosomatic Medicine*, X:5, 254-256, September-October 1948.

small numbers of patients operated upon, it seems reasonably clear that topectomy involving areas 9 and 10 (and perhaps 46) not only gives the relief from overpowering affect which is generally considered the principal benefit of successful lobotomy, but averts some of the dangers, drawbacks and uncertainties of that procedure.

As for the secondary objective, hope that the mechanism of improvement could be elucidated, the Greystone operations appear to have shown that the reduction of painful affect follows the removal of "a specific site at the junction of areas 9 and 10," while the removal of too much cortex, regardless of site, has results resembling those of lobotomy, "tactless, carefree, irresponsible behavior with lack of initiative and absence of remorse." The investigators found behavior of this type in the patients who underwent successful lobotomies, in a short lobotomy series instituted as controls for the topectomy experiment.

A third objective, the collection of all "incidental" information possible, appears to have resulted in a mass of data which will be a foundation for years of future research. As instances, observations casting doubt on the commonly-held views of the function of Broca's area and the failure to find constant or specific pathologic changes with present neurohistologic techniques, might be cited.

For the future of this operation, it should be remarked that the investigators appear to agree that topectomy at the areas found to be critical produces the benefits without the serious ill effects of lobotomy. The psychological studies, which we cannot attempt to summarize here, involved a highly impressive battery of examinations by a large group of skilled examiners. They indicated no permanent adverse effect on intelligence and no other adverse effects which were not considered to be counterbalanced by observable benefits. Actually less change was encountered than that following shock therapy. The neurological examinations similarly demonstrated—in operations confined to areas 9, 10 and 46—the lack of serious complications or sequelae. There were no convulsions, a common consequence of lobotomy, following ablation of the critical regions in areas 9 and 10 only.

The Columbia-Greystone workers are exceedingly conservative themselves in discussing therapeutic indications and possibilities. Curry and the late Henry A. Cotton, Jr., note: "It should be em-

phasized that topectomy, if used at all, should not be resorted to until after the possibilities of other forms of treatment have been exhausted. Also, when patients are subjected to neurosurgery, full use should be made of psychotherapy and its various adjuncts." And Mettler and Curry report of the patients actually operated upon, "It is unnecessary to say that no patient was included in the study who had not already undergone every known, accepted form of therapy which seemed to offer any promise." And again in discussing the problem of possible operations on psychoneurotics, Heath, Weber and Crandell remark: "Our clinical studies and the psychological tests undertaken thus far indicate that relatively little is sacrificed by the patient as a result of a small specific area removal. Regardless of this, we must consider first and foremost that brain tissue is being removed and it can never be replaced. This procedure cannot become a substitute for adequate and skillful psychotherapy." And this comment is made despite the fact, which the writers note, that it is apparent the operation can afford relief from intractable neurotic tension.

The authors believe that the specific effect of topectomy is "to alter the affective response so that tensions do not accumulate, thereby making regressive-reparative behavior unnecessary." They regard patients with agitated depressions, involutional agitated paranoid states, manic-depressive depressions and schizophrenia with affect appropriate to ideation, as suitable for operation. They feel further that the schizophrenic in danger of rapid deterioration should be operated on early, and warn against repeated courses of shock therapy lest such deterioration be masked. They report that the manic patient is not benefited, and advance an explanation therefor.

With all cautions and qualifications, the advance which topectomy represents may be a leap across many centuries. Brain surgery following traumata or for tumors has become a commonplace—if still a most difficult—specialty. Brain surgery for mental disorder has not, although Burekhardt reported cortical removals in 1890 and operations on the skull were made far back in prehistory. Trephining or trepanning was practised by the ancient Peruvians in particular. Since the operation seems to have been performed in cases where traumata are not evident, there has been reasonable speculation to the effect that the skull was opened to give exit routes to the devils of mental derangement. And since

there is evidence that at least some patients survived, the fascinating speculation is permissible that ancient South Americans saw the first successful lobotomies. One may then wonder as to the amount of increased understanding of what the operator was doing between the days when a priest manipulated a stone-tipped drill and the start of the Columbia-Greystone experiment. Between the driving-out of pre-Incaic devils and the amputation of the Freudian super-ego—which was the rationale advanced for lobotomy in a widely-publicized popular magazine explanation a few years ago—there seems to be little to choose.

Topectomy should lessen the number of wilder explanations. The procedure seems to have demonstrated that a discrete cortical area at the junction of Brodmann's areas 9 and 10 functions in the production of anxiety and unduly painful affect, and that the good results of all varieties of psychosurgery reported so far depend on the ablation or disconnection of this site. Even this is to be accepted with caution. The patients who had areas 9 and 10 removed appear to have had a somewhat better expectancy than those subjected to removal of other areas; and a completely fair trial of other areas is now an objective for future research. Carney Landis in particular takes exception to conclusions that loss of anxiety and pain following ablation of areas 9 and 10 is specific to those areas; and he adds that "no existing theory or hypothesis dealing with the psychologic significance of the human frontal lobes is tenable." He sees the Columbia-Greystone study, however, as clearing the way for a "comprehensive investigation which should lead to new knowledge which will be meaningful." And it is Landis who concludes:

"The topectomy operation is a therapeutic procedure in the same way that removal of part of the thyroid gland is a therapeutic procedure for goiter. In each instance there results a decrease in emotional tension, and, when successful, a better life adjustment. Removal of areas 9, 10 and 46 of the frontal lobes permits the restabilization and orderly balance of psychologic functions in mental patients who have much self-referred anxiety together with many mental and physical complaints."

There are other reasons than the authors' caution for not anticipating any rapid emptying of our mental hospitals by topectomy operations. The operation itself is expensive and time-consuming. The time required, it is reported, has now been reduced

to as little as three and one-half hours; in the series at Greystone actual times varied from four hours and 30 minutes to eight hours and 15 minutes. The procedure involves surgery of the highest skill; it cannot be reproduced in a few minutes by an intern with an ice pick. And for the favorable results of the Columbia-Greystone research, expensive and time-consuming psychotherapy, plus the environmental and other factors employed in the "total push" method, were added to the surgery itself—be it noted, for the control group too. Disregarding the research workers completely, a carefully-prepared environment and a large and carefully-trained personnel were necessary. These things cannot be evoked at the ordinary mental hospital by gazing into a crystal ball.

As we see it, the epoch-making character of the Columbia-Greystone project is less in the results reported or the therapeutic hopes raised than in the road it takes. It was an unprecedented piece of co-operative research in which painstaking preliminary organization prepared for virtually every possible foreseeable avenue of inquiry and in which the best available talent of the allied scientific fields was called upon to join. The Columbia-Greystone neurosurgeon did not attempt psychiatric evaluations; the psychiatrist did not fumble with neurology or psychology; independent investigators worked within the framework of those disciplines with which they were thoroughly familiar. The results were reported frankly and objectively. For instance, there is no pretension to extreme exactitude in reporting the areas excised; and it is carefully pointed out that observers differed as to effects, if any, of operative impingement on areas adjacent to those selected for ablation. Similarly, the surgeons note where improvements (since adopted) could be made in operating technique; they caution, for example, that the electric cautery—which was used sparingly and with great care—should not be used at all. There are similar comments concerning anesthesia.

But the report of this project forms much more than a guide to what to do and what to avoid in psychosurgery. It is a guide to future psychiatric research. If prefrontal lobotomy is a stab in the dark—justified by the fact that many lobotomized patients improve—it is by no means the only stab in the dark in psychiatry. With all the extensive studies made on the other physical procedures in common use, none at all comparable to this co-operative endeavor has been undertaken. We could well make use of

similar research on insulin coma and subcoma therapy, metrazol, electric shock and their combinations. We could use comparable information on certain psychosomatic conditions, gastro-intestinal disorders for example. We need such information on various forms of psychotherapy, from group methods to hypnoanalysis. We could make excellent use of co-operative research data on such various social and environmental procedures as "total push," conventional occupational therapy, family care and clinic after-care.

One would not suggest, of course, that the Columbia-Greystone set-up or even the Columbia-Greystone general plan should be pursued indiscriminately in all directions. But its careful advance-charting of foreseeable possibilities, its method of selecting and utilizing controls, its enlisting of expert specialists and its outline for controlling and co-ordinating their work, all offer themselves as models for future investigators. We have here, if we can find the will and the way to use it, the most promising means presented in many years for casting light on many of psychiatry's dark places.

## REFLECTED IN A GLASS DARKLY

In the last two years, THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT have published no less than 100 book reviews of psychiatric and psychological fiction. Despite public relations campaigns and the mental hygiene movement, psychiatry still appears to be among those human endeavors which is known less by its own works than by the works of others about it.

Serious fiction, like other *belles-lettres*, is supposed to have among its functions the holding up of a mirror to human life. We conceive that the images which reflect our own lives and the lives of those with whom we have professional concern or personal relationship are more often than not distorted in contemporary psychological fiction to caricatures, or even to the point where they are not recognizable.

Psychological fiction in the form of folk-tale, drama, allegory, and recently the novel, has a history which probably antedates the invention of writing. In early English literature, there are psychological tales in Chaucer. The great Elizabethan tragedies, *Hamlet*, *Lear*, *Macbeth* and Marlowe's *Faustus*, were psychological.

In the nineteenth century, Wilkie Collins wrote *The Woman in White*, with its setting of a private mental institution; George du Maurier based *Trilby* on stage hypnosis; Robert Louis Stevenson wrote of personality dissociation in *Dr. Jekyll and Mr. Hyde*. But there was much distortion here; Collins spread fear of false imprisonment; du Maurier popularized dangerous misconceptions of hypnotism; Stevenson obscured an excellent psychological presentation by the hocus-pocus of medical magic through which he wrought physical changes supposedly appropriate for the mental ones. Only Nathaniel Hawthorne broke completely through nineteenth century superficiality and misunderstanding. His *Scarlet Letter* is an inspired study of guilt, beyond the slightest doubt the finest fictional study of guilt in the English language, and possibly in any language.

Today's psychological novel can claim respectable literary ancestry in these nineteenth century tales and in such works as Mark Twain's *Mysterious Stranger*, the horror stories of Poe, and occasional excursions into psychopathology by Dickens, Thackeray, Emily Brontë, Meredith, Hardy and others. On the other side of

the family, the psychological derivation may be conceived as a primary *mésalliance* between Freud and Krafft-Ebing, complicated by numerous other illegitimacies along the line of descent. It is not surprising that the progeny should present all the variants of good, bad and indifferent writing and should have characteristics ranging from genuine insight to purely mechanical, intellectual understanding or misunderstanding of psychodynamics. That there is more intellectual parroting than true insight is a conclusion which is not only supported by observation but would be a safe assumption in any event; for psychological fiction has become a fashion like the fashions in romantic and historical fiction which followed Walpole and Scott; and insight cannot become a fashion.

It was long after Freud had pried up the lid on the Pandora's box of the human mind that the complex, the fixation, the -philia, the phobia, the obsession, the compulsion, and the manifold derangements of schizophrenia flew over the academic medical walls and began to infect general literature. Hall Caine's writings, for example, had more of a psychological atmosphere than a psychological content; event still overshadowed motivation in Somerset Maugham's *Of Human Bondage*; frustration and aberration in the early novels of Hemingway and Faulkner were still subordinated to action; the numerous stream-of-consciousness novels of the early 1920's were, of course, as superficial as consciousness is in relation to the psyche as a whole.

The psychological novel of the contemporary type had its birth, however, in those same 1920's. Although its content was in large part virtually the transcript of testimony in an actual murder trial, Dreiser's *An American Tragedy* was a truly psychological tale. So was Radclyffe Hall's *The Well of Loneliness*, the first important fictional defense of homosexuality since Oscar Wilde, and a tremendous literary success. Rosamund Lehmann's *Dusty Answer* was another significant psychological work of the same period; and it dealt with the same problem. T. S. Stribling's psychological fantasies, most of them undeservedly buried in pulp publications, appeared at this time; and Steinbeck's novels, often as much psychopathological as sociological, followed a few years later during the depression.

With World War II, came such an outpouring of psychological fiction as to become the main current of the contemporary literary stream. One would hesitate to assign the cause to the war, for

this type of novel has predominated in recent years in general as well as in war fiction; and it seems probable that the themes derived from a common source.

The novel of homosexuality, at least, has continued in the direct tradition of *The Well of Loneliness*. *The Well of Loneliness* was a moving book of considerable power and considerable beauty. It was a much-needed plea for tolerance in an intolerant and bigoted world. But the evil it wrought has been much more considerable than the good. It spread the mischievous doctrine that homosexuality was congenital and incurable, deprived relatives and victims alike of any hope of cure, and persuaded others that since their aberrations were inevitable they might as well relax and enjoy them. In Charles Jackson's *The Fall of Valor* and Stuart Engstrand's *The Sling and the Arrow*, Messrs. Jackson and Engstrand present these pernicious assumptions to current readers, spreading hopelessness and/or complacent acceptance, and altogether doing as signal disservice to the cause of mental hygiene as has been seen in recent times.

Since Engstrand's publishers advertised the fact that the author got his idea for *The Sling and the Arrow* from reading Stekel on abnormal psychology, this seems an appropriate place to observe that sound psychological fiction does not and cannot stem from the study of textbooks. One might as well try to produce live humans by mating an anatomy and a physiology. Sound psychology in fiction must derive from the unconscious of its author—it must also derive from emotion as well as intellect; it must be the substance of things felt, not learned by rote, it must be written from inner need, not as an intellectual exercise. It would be a supreme absurdity to hold that formal study in itself can prevent good writing—if so, we would not have some of the excellent fiction we have had from psychiatrists, social workers and successfully-analyzed writers. Fiction derived from insight, which is unconscious as well as conscious understanding, certainly cannot be harmed by intellectual comprehension; but intellect without insight is inadequate to depict sound psychology, as the intellectual misunderstandings of Engstrand and Jackson abundantly demonstrate.

It should be said here that Jackson and Engstrand are fortunately not entirely representative of contemporary writing. There has been much "adequate" psychological fiction, much indifferent,

a little which justifies the description of excellent and a comparatively small amount which is very bad. Most World War II fiction, for example, seems to be of the better-than-adequate level.

War fiction before World War I was largely preoccupied with adventure or romance—with the notable exception of Stephen Crane's *Red Badge of Courage*. World War I fiction—in English—was largely objective realism, a study of the repulsive sights, sounds and smells of the battlefield; the best psychological studies of World War I were German. World War II fiction has been closer to the spirit of *The Red Badge of Courage*; and this publication's reviewers seem in general agreement that psychologically it has a high degree of validity. Norman Mailer's *The Naked and the Dead* has been described as a study of the unconscious of a platoon in action; and its rating both as literature and psychology is accepted as close to a masterpiece. A random selection of fiction dealing either with the war or with post-war adjustment, and ranging from psychologically adequate to excellent, might include Robert Lowry's *Casualty*, Luigi Creatore's *This World Is Mine*, Prudencia de Pereda's *All the Girls We Loved* and Larry Barretto's *The Great Light*. Guisepppe Berto's *The Sky Is Red* (translated from the Italian) and Robert Neumann's *Children of Vienna* are very good portrayals, indeed, of the suffering wrought by war on the civilian population.

Contemporary psychological fiction in general, however, cannot be accorded any such sweeping, if greatly qualified, approval. And in quantity, it is overwhelming. A reviewer, writing in Part I of THE PSYCHIATRIC QUARTERLY SUPPLEMENT for 1948, has explained why we have attempted to cope with it. In making plain why he felt a strong protest against an ill-conceived piece of fiction was indicated, he remarked that he felt "the book section of this journal performs a unique function, strangely enough neglected by other psychiatric publications: It watches over the use and misuse of our science by writers." This is a task which was undertaken before we were well aware of it and which seems to be growing in size and importance. And the conclusions derived from it are not easily summarized.

One may note at the start those writings which primarily concern us personally or which have our institutions as settings. In the last few years, two important novels have been written about the New York State hospitals: Ellen C. Philtine's *They Walk in*

*Darkness* and Mary Jane Ward's *The Snake Pit*, with its moving picture sequel. *They Walk in Darkness* was an embittered satire by a physician's wife, well calculated to club their personality defects—real and imaginary—into the thick skulls of the public hospital medical personnel. But it did vast harm to the morale of patients' relatives and the mental hygiene movement in particular. Ellen Philtine's patients walked in darkness—neglected, dirty, ill-fed, miserable, and subjected to the control of selfish, incompetent, calloused, medical failures whose chief human attribute was the need for security implied in a state job. Mary Jane Ward's *Snake Pit* was a much clearer and much better picture. A former patient, her fictional account of personal experiences neither glossed over nor exaggerated unpleasant conditions; she reported smells, unappetizing food, lack of privacy, the distress which can be caused by a sadistic attendant or uncomprehending physician; but her total picture was one of sustained effort to provide good care and seek cure. Together with the motion picture based on Mrs. Ward's book, a picture obviously filmed with the benefit of professional advice and assistance, *The Snake Pit* has proved valuable, we feel, in acquainting the general public with mental hospital conditions and in pointing to overcrowding, the need for more therapists, and the need for better preparation of food, as conditions calling for action.

Of other fiction with an institutional background, one may cite Leonhard Frank's *Dream Mates*, an utterly impossible story of two deteriorated schizophrenics "in love," which it is pleasant to think had small circulation and even less influence. Still another is Anna Kavan's *asylum piece*, a series of sketches of patients which conveys very well the atmosphere of the mental institution.

The individual therapist has also had good treatment and bad. Henry and Katherine Bellamann in *Parris Mitchell of Kings Row* wrote a moving and psychologically-sound biography of the youth and early practice of a young psychiatrist. So did Daniel Taylor in *They Move with the Sun*, for Daniel Taylor is the pseudonym of a physician who plainly writes of what he has either seen or experienced. Phyllis Bottome is so close to the Adlerian school that her writing may be considered almost official interpretation; bearing her orientation in mind, her novel, *Survival*, can be commended as a fine presentation of the Adlerian point of view, although non-Adlerians can quarrel with its broadcasting of what they may con-

sider superficial psychology. Similarly, Dr. Frederic R. Stearns' *The Lattice Window*, dealing with a psychotic psychiatrist, will be assessed according to the critic's individual orientation.

The lay analyst and the medical profession both receive a rough deal from Nigel Balchen's *Mine Own Executioner* in which the fictional analyst's ambivalence toward his profession seems equalled only by the author's own ambivalence toward analysis. Allan Seager's *Equinox* is a not-too-plausible tale of the deliberate misuse of psychoanalytic principles by a presumably half-analyzed sadist—its implications are dangerous misconceptions for general reading; and its psychology is probably unsound. It is fair to say that Seager's sadist is not presented as an analyst; but it is also fair to say that the uncritical, general reader will jump to the conclusion that here is an analyst happily engaged in malpractice to the point of criminality.

On the same theme, the misuse of analytic concepts, but with the reverse of the coin showing, is Hannah Lees' *The Dark Device*, a widely-circulated plausible and exciting tale of a father's—conscious or unconscious—employment of dynamic psychology to enslave and torture his children, who are finally led to freedom by a psychoanalyst. But *The Dark Device* is closer to the detective or mystery story than to a portrayal of therapy. And the detective story is often better psychologically and psychiatrically than the majority of more pretentious literary efforts, which is not so strange as it may first seem, for the writers of the better "who-done-it's" include not only first-rate literary craftsmen who study their backgrounds, but more than a few who appear to write out of inner need and so bring some emotional reality to their tales.

Thus Hannah Lees, with a psychiatric background, collaborates with Lawrence Bachmann to write, in the mystery, *Death in the Doll's House*, as good an exemplification of play therapy for children as can be found in the scientific literature. Carter Dickson (John Dickson Carr), in *Seeing Is Believing*, gives a sound, modern exposition of hypnosis and its limitations, which would be endorsed by most present-day authorities. And Dorothy Sayers endows her aristocratic detective, Lord Peter Wimsey, with a credible and pitiable neurosis precipitated by World War I experiences. There are other good examples: Margaret S. Marble's *The Lady Forgot*, a mystery of amnesia, and Rosemary Kutak's *I Am the Cat*, which, if somewhat mechanical, is still a faithful illustration

of Theodor Reik's murder theories. The merely adequate, the mediocre and the outright damaging should be noted. The worst can, perhaps, be dismissed with a shrug, for psychological caricatures of the extreme variety are usually accompanied by other literary defects. In the most horrible example we can recall readily, *I, the Jury*, by Mickey Spillane, an incredibly beautiful and blond Park Avenue lady psychiatrist strips to offer her fair white body to the hard-boiled detective who has just discovered she is a murderess. This ludicrous scene, however, is preceded by so many patent absurdities that it is difficult to believe that even the most naïvely prurient can take the book seriously—and we may feel that public rejection of this type of fiction is likely to be general, at least in respect to the detective story.

The novel of alcoholism has set a recent fashion in psychological fiction. Where these tales have been descriptive, they have, as a rule, displayed more than a little insight; where they have touched on therapy, they have been generally unobjectionable as reflecting current, conventional theories and methods. Outstanding, of course, has been Charles Jackson's *The Lost Weekend*, which unfortunately for him became a best-seller and encouraged him to follow it with two vastly inferior books, the highly objectionable *Fall of Valor* and the poorly conceived *The Outer Edges*, which conveys a great misunderstanding of the psychology of murder. Following Jackson's original alcoholic trail, are such books as Louis Paul's *Breakdown*, Natalie Shipman and Gurdon Saltonstall Worcester's *Perchance to Dream*, and Langdon Moffett's *Devil by the Tail*, which is excellent propaganda for Alcoholics Anonymous. To these should be added Malcolm Lowry's remarkable story of delirium tremens, *Under the Volcano*.

One should note that neither previous literary repute nor genuine pre-eminence is any warrant for the psychological validity of current work, as witness Jackson's first and later books. And no human beings, well or deranged, ever acted like Robert Briffault's characters in *New Life of Mr. Martin* or Sinclair Lewis' in *Kingsblood Royal*—yet Briffault's earlier novels were marked by genius; and Lewis' previous work has been of high grade, psychologically. Neither, of course, does thorough acquaintance with background assure more than good background; the characters of Frederic Wakeman's *The Hucksters* (which may owe its phenomenal success to having made a dirty word of "sincere") are doubt-

ful figures; while Charles Yale Harrison's *Nobody's Fool*, with a very similar setting, is perfect psychologically.

Similarly with the psychological fiction of social phenomena! Laura Z. Hobson's *Gentleman's Agreement* is a psychologically-sound and moving plea against anti-Semitism. Jo Pagano, making an equally praiseworthy attempt to deal with another disgraceful social phenomenon in *The Condemned*, oversimplifies, misunderstands, and misleads dangerously in inferring that his sadistic butcher has somehow benefited by getting something out of his system through taking part in a lynching. While the author does not suggest it directly, there is, somehow, the curious implication in this book that taking part in cruelty is good for some people—a ready-made apology for mob violence.

Yet there is insight, sympathy and sound psychology in a surprisingly large number of the modern psychological tales. Robert Paul Smith's *Because of My Love* is a small masterpiece, an almost perfect story of the outbreak of schizophrenia; Matthew Head's *The Accomplice*, I. S. Young's *Jadie Greenway*, Saul Bellow's *The Victim*, Adeline Rumsey's *The Other Children*, are among sound, recent works in the field of personal or social psychological problems. In anthropology, Vardis Fisher's *The Golden Rooms* and *Adam and the Serpent* are well-done psychoanalytic interpretations of man's prehistory. In the unlikely field of fantasy, there is good, if by no means perfect, psychology in Henry Morton Robinson's *The Great Snow*, Pamela Kellino's *De! Palma* and Josephine Pinckney's *Great Mischief*.

All this hop, skip and jump across the broad field of modern fiction is intended to lead toward the conclusion that if psychiatry and psychology are getting a bad press, are too often shown with their club feet in front, or are too often caricatured beyond reasonable recognition, it is in large part our own fault. We did not choose it so; but by far the greater part of the impression we now make on the public in general is through fiction. It is an impression which we have, for the most part, painstakingly disregarded; but we think it is long past the time when it could safely be ignored.

We recall such reactions in the past as the irate, futile and presumably not serious suggestion of a colleague that books like *The Well of Loneliness* be prohibited by law. We want no truck with

the manifold evils of censorship—which are far worse than any fictional misrepresentation of our specialty could be. But between censorship and the bland ignoring of fictional misrepresentation, there are many paths which may be explored. As individual psychiatrists, as members or representatives of professional or mental hygiene organizations, as writers or commentators, there is much we can do.

It is reasonably safe to assume that most writers of psychological fiction and most publishers of it are persons of professional pride and will not be deaf to considerations of accuracy—except where there are strong emotional reasons for unconscious misrepresentation. It is also not too much to hope that at least some publishers can be brought to see the value and common sense of obtaining sound professional advice before going “all out” for a book dealing with psychiatric problems. There seems good reason to think some are doing so already. One may entertain similar hopes also in relation to the literary critics. A literary critic qualifies for his work by a certain facility with his own pen, plus reading acquaintance or scholastic background in contemporary and older literature; he knows syntax, rhetoric and a multitude of clichés; he may be a sound, or even a profound, psychologist; but he also may be, and often is, as psychologically ignorant as a day-old calf. Some of the worst-conceived and most unsound of our psychological fiction has won praise—and consequently passed on to wide circulation—from the ignoramus variety of critic. But, since much of the critic’s ignorance is non-malignant, since his attitude toward the public is generally not malevolent, we should have the strength to make our own points clear to the critic as well as to the other people who stand at our literary sources.

As individuals, we can often pass the word to interested friends that this novel is good psychologically—or has been reviewed as good psychologically—or that this other book, or that, is indifferent or bad. We can call psychiatric fiction to the attention of professional groups and encourage its discussion by professional groups. In some cases, we may be able to pass professional opinion on to librarians or book buyers—the editors have been surprised to learn of one retail book buyer who consults this publication’s reviews as a guide to psychological and psychiatric fiction.

In summary, the greater part of our public relations—despite psychiatric educational endeavors and the mental hygiene movement—has been in a field beyond our control. Fiction has been, and will probably remain, the principal mediator between our sciences and the public. We suggest that we must take it seriously as such. Judicious attention on our part to the field of writing for entertainment might serve us better in the end than a multiplication of our formal public relations efforts.

## BOOK REVIEWS

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**Current Therapy—1949.** Latest Approved Methods of Treatment for the Practicing Physician. Howard F. Conn, M. D., editor. 637 pages. Cloth. W. B. Saunders Co. Philadelphia. 1949. Price \$10.00.

All physicians will agree that textbooks are really out-dated when printed, not because of content relating to symptoms and diagnoses described but because of rapidly-changing methods of treatment. To keep up with methods of treatment, the doctor must purchase books containing reviews of literature or read literature published by drug concerns. For this book the editors have selected only the most recent and the most important references on treatment and have avoided the use of unreliable medical literature.

This book is best described by quoting parts of the editor's preface as follows: "In this book for the first time an attempt has been made to furnish the busy practitioner not only with the latest method of treatment of a particular condition, but a method that has been endorsed and is currently used by a competent authority.

"In order to secure these approved methods of treatment a board of twelve Consulting Editors was selected. This board of Consulting Editors in turn selected authorities to write original articles on the specific treatment of given diseases. As a result over two hundred leading American physicians have contributed to this volume.

"Throughout the book, it is presupposed that the diagnosis has already been established. . . .

"In many instances the methods of two or more authorities for treating a single disease have been included, where there are existing variations in the standard therapy. . . . There is no claim, of course, that all known methods of treating the diseases listed have been included."

The book contains 14 sections: infectious diseases, diseases of the digestive system, of metabolism and nutrition, of the endocrine system, of the urogenital tract, the venereal diseases, diseases of allergy, of the skin, of the respiratory system, of the cardiovascular system, of the blood and spleen, of the nervous system, obstetric and gynecologic conditions and diseases due to physical and chemical agents. There is an index at the beginning of each section, and a huge general index and an index of authors at the end of the book. The volume is attractively bound, nicely printed and should be a popular one.

**T. S. Eliot:** *The Design of His Poetry.* By ELIZABETH DREW. 212 pages. Cloth. Scribner's Sons, New York. 1949. Price \$3.00.

This book represents a naïve and out-of-focus attempt at "explaining" Eliot's poetry along Jung's lines of simplified reasoning. After declaring her own unfamiliarity with psychological topics ("But this is not a book about rival schools of psychology and anthropology; I have very little knowledge of either, and am in no way qualified to judge them"), the author does not let it go at that but proceeds merrily to act the psychological expert. Unfortunately, her initial self-criticism is the only critical part of the book; otherwise, ignorance of the psychiatric ABC is rampant. She refers to facts concerning differences of opinion between Freudianism and Jungianism incorrectly, as far as the Freudian viewpoint is involved. Freud is known to her seemingly only from *Totem and Tabu*; this is the only book of the founder of psychoanalysis which she quotes—and that in a few sentences. What happened after 1913 is obviously of no interest. The sheer amount of confusion which Miss Drew produces is remarkable: She confuses (a) repression with suppression; (b) the newer development of analysis with its beginnings; (c) the reasons for the conflict of Freud and Jung; (d) literary popularization ("elucidation") with unconscious meaning; (e) unconscious clarification with the act of judgment of distinguishing "between good art and bad"; (f) specific symbolism with a dictionary of standardized formulas, etc., etc. She obviously has never heard (or conceals her knowledge very successfully) of the pre-Oedipal phase of human development, or of the work of Freud since 1913 (Freud died in 1939) and of his pupils—Jones, Sachs, Rank, Reik, Brill, Bergler, Sharpe, to name a few—who devoted part of their work to studies of the artist's unconscious. Moreover, the author excels in circumlocution at its worst. The heights of absurdity are reached when Eliot's well-known anti-Semitic utterances ("Burbank with a Baedeker, Bleistein with a cigar") are explained in "patterns of interweaving oppositions," which obviously means "opposites."

A cynic once said that in a free country, not subject to any official "party line," everyone is free to subdivide people after any principle he chooses; for himself, that wit reserved the right to divide poets into Buddhists, users of cigarette-holders and anglers. That gag comes to mind when Jung's archetypes are used as guiding principles of Eliot's poetry and imagery. Considering subdivisions, one wonders after what principles, if any, publishers sometimes "subdivide" in the matter of psychological works. Unfamiliar with newer psychiatric trends, their editors seemingly follow the rule: If something is written with eloquent circumlocution, it must be good. It is rather grotesque and to be regretted that Miss Drew's book is announced by a serious publisher as "indispensable to the reader of

Eliot—it is also an exciting voyage of discovery into the creative process.” The book should be looked through by anyone who wants to convince himself of the hollowness of literary criticism which ignores psychological facts. It is truly a warning example.

**Psychological Medicine.** By DESMOND CURRAN, M. D., F. R. C. P., D. P. M., and ERIC GUTTMANN, M. D., M. R. C. P. 246 pages. Cloth. The Williams and Wilkins Co. Baltimore. 1945. Price \$3.50.

This second edition of the original, shorter introduction to psychiatry contains an appendix on psychiatry associated with war conditions. Etiology of mental disorder is taken up in psychological, physical, and constitutional factors. Symptoms and treatment are adequately discussed. Constitutional anomalies, organic syndromes and psychiatric aspects of head injuries are also well covered. Drug addiction and the legal aspects of mental illness are also discussed. As in most British textbooks, the affective psychoses are presented from the standpoint of reaction types. The most valuable part of this volume appears to be the appendix on psychiatry associated with war conditions. This discusses general principles of mental illness encountered in service patients, with a discussion of the examination routine, the clinical syndromes and their management and treatment. In the chapter on schizophrenia the newer forms of therapy are covered, including insulin and electric shock and leucotomy. While this volume is much abbreviated, it is, nevertheless, valuable as a quick review of the basic principles of psychiatry.

**The Selected Writings of Benjamin Rush.** Dagobert D. Runes, editor. The Philosophical Library. New York. 1947. Price \$5.00.

Benjamin Rush, early American scientist and social philosopher, was a man far in advance of his time who serves as an ennobling example to modern medicine. If some of his theories—looked at askance by no lesser celebrities than George Washington and Alexander Hamilton—had been put into practice after the revolution, it is not likely that two centuries would have elapsed before reaching our present stage of progress.

From the thousands of Rush's writings Runes selects 29 significant articles composed between 1772 and 1805, arranges them interestingly in four divisions: On Good Government, On Education, On Natural Medical Sciences, On Miscellaneous Things. These fully convey the weight of the doctor's valuable achievement and extraordinary outlook.

It is easy to imagine Rush's stand on health insurance, civil liberties, discrimination and totalitarianism of all kinds. Modern physicians are on the whole not so intimately connected as he with the workings of our government. That does not mean that they cannot benefit from a review of the precepts of one who was.

*The Selected Writings of Benjamin Rush*, in short, is required reading.

**Japan Diary.** By MARK GAYN. X and 517 pages. Cloth. William Sloane Associates, Inc. New York. 1948. Price \$4.00.

*Japan Diary*, by Mark Gayn, is an eye-witness account of Japan and Korea immediately following the recent war and into almost the middle of 1947. The narrative is in diary form, but it gives us more than a mere diary: It has basic implications; it abounds in facts; it has sound insight. The author writes plainly about his tours into remote villages, his interviews with premiers and war criminals, his trips to rural prefectures, his discussions with military personnel.

*Japan Diary* is a close-focus account of America's attempt to re-make Japan in its own image. The author is frankly skeptical. He is critical. Mr. Gayn wonders if the Japanese are really adopting democratic principles. He is concerned with the realities in Japan, not the appearances.

It is obvious that Mark Gayn has a long and extensive knowledge of the East behind him. He has implemented his understanding of Japanese psychology with talks with tenant farmers in Japan, landowners, cabinet members, ex-generals, labor leaders, industrialists, and politicians. He has written interestingly of one of the troubled and troublesome places in the world. His style is vivid, mostly objective, and rather smooth. The book is a satisfactory addition to the ever-growing library of "Japaniana."

The picture that emerges from *Japan Diary* is of a nation in ferment; of democratic elements working to take advantage of their apparent new freedom; of the old Japanese militarists still biding their time, supremely confident, waiting for the time ahead. Mr. Gayn indicates that the American occupation started off with high ideals and even wise directives; but he gives evidence in his book that perhaps Japan is now more important as a bulwark against Russia than as a possible home for democratic institutions as we know them.

**The Hero with a Thousand Faces.** By JOSEPH CAMPBELL. 416 pages with index. Cloth. Pantheon Books. New York. 1949. Price \$4.00.

This is the very old story, from myth to dream, of the primordial hero—his birth, his trials and his fate. Jason, Theseus, Osiris, Joseph, Jonah, Perseus set forth on the adventure, undergo initiation and return. The hero is born of a virgin; he undergoes transformations; he is a warrior, an emperor, a tyrant, a redeemer and a saint.

One may recall here Edward Carpenter, Sir James Frazer and others. but Campbell has interpreted the hero in the light of Freud, Róheim and Jung—the social and individual unconscious.

This book is Number XVII of a series sponsored by the Bollingen Foundation, Inc. It is a very worth contribution, indeed, for study by all those interested in individual or social psychodynamics.

**The Yearbook of Psychoanalysis.** Volume 3, 1947. Sandoz Lorand, M. D., managing editor. 309 pages, with list of selected reading. Cloth. International Universities Press. New York. 1948. Price \$7.50.

It requires a certain temerity to select any of the 20 excellent papers in this yearbook for discussion. They cover many aspects of the field, from technique to history and philosophy. "Sleep, the Mouth, and the Dream Screen," (p. 61), by Bertram D. Lewin, M. D., bids fair to be one of those contributions which cannot fail to influence the course of psychiatric thinking in the future. The dream screen is described as "the blank background, present in the dream though not necessarily seen," on which "the visually perceived action" occurs. In further explanation: "The dream screen is the representative of the wish to sleep. The visual contents represent its opponents, the wakers." As far as the reviewer is aware, nothing similar to this dream screen has been described before. Ernest Jones, M. D., presents some general remarks about the development of psychoanalysis in "A Valedictory Address," delivered before the British Psycho-Analytical Society in 1946. In the progress of acceptance of analysis, he speaks of the approach of Darwin and Freud toward controversy: "these men countered the savage attacks on their work in a very simple way—by producing more work." Walter Bernard, Ph.D., points out the many similarities between "Freud and Spinoza," in his paper of that title.

Mention of these titles is intended only to give an idea of the scope and diversity of the subjects treated in the yearbook, and to show that any psychiatrist will find here abundant material according to his interests.

**Studies in Analytical Psychology.** By GERHARD ADLER, M. D., F. B. Ps. N. 250 pages with index, 19 illustration. Cloth. W. W. Norton & Company, Inc. New York. 1948. Price \$4.00.

The author of these studies is recognized as one of the foremost apologists for the Jungian attitude toward the unconscious. His exposition is as clear as the nature of the material permits, but it must be recognized that his views on dream interpretation, symbolism, religion, and the role of the ego are a little different from those commonly held in medical psychology. In explaining these differences, the author provides many new ideas and procedures which may be found useful in general psychotherapy, such as "amplification," the therapeutic and prognostic use of drawings, "active imagination," and "conversation with the personified contents of the unconscious." There are 19 illustrations to implement the discussion in the text.

**Sexual Tensions in Marriage.** The Origin, Prevention and Treatment.

By TH. H. VAN DEVELDE, M. D. 330 pages. Cloth. Random House. New York. 1931. Price \$7.50.

**Fertility and Sterility in Marriage.** Their Voluntary Promotion and Limitations. By TH. H. VAN DEVELDE, M. D. 388 pages. Cloth. Random House. New York. 1931. Price \$7.50.

These two volumes are reviewed together because they are companion volumes really belonging to a trilogy with *Ideal Marriage* by the same author. They are re-issues; and there is a story behind the original trilogy which your reviewer believes is correct. Over 20 years ago Van DeVelde began to conduct a gynecological clinic in Switzerland; he wrote from his experiences to enlighten the laity. *Ideal Marriage* created much comment of a joking, as well as of a serious, nature as it was not only extremely frank but contained a number of illustrations. At any rate it was apparently a book which the public had been seeking and seems to have been the first published for popular consumption. If, therefore, much of the material written in these volumes is quite commonplace to the reader, the author can be forgiven.

*Sexual Tensions in Marriage*, which was translated from the German by Hamilton Marr, M. A. (Cantab), describes in detail the various factors which cause hostility in marriage, showing that they lead from aversion to antagonisms. The second section of this book deals with prevention and treatment. The author emphasizes the need for wise choice of a marital partner, for insight and adaptability and for practical sexual knowledge. This volume does not contain a bibliography or an index.

*Fertility and Sterility in Marriage*, which was translated from the German by Stella Browne, considers such problems as sexual abstinence, family limitation, the physiological and psychological factors leading to a desired pregnancy, the significance, causes and mechanisms of sterility in women, the physical and psychic factors of impotence in men, the use of artificial insemination and finally, the prevention of undesired conception. This volume contains a bibliography and several anatomical plates, but no index.

**The Wastrel.** By FREDERIC WAKEMAN. 252 pages. Cloth. Rinehart & Co. New York. 1949. Price \$2.75.

Frederic Wakeman's literary progression seems to be the tragedy of a man who, under the impact of exceptional emotional stress, created one well-rounded satiric figure (the old soap magnate in *The Hucksters*), and from that day on, proceeded to a task ill-suited to a handy copywriter. Copywriting and productive writing are not identical, a fact already evident in the inept love story of *The Hucksters*.

*The Wastrel* tells—with one eye on Hollywood—the story of a “sports-fisherman” and his young son, stranded on a raft in the ocean, after their boat has been blown to pieces. The long hours of waiting for rescue, give the father now “on the wagon,” the opportunity of reviewing in “self-analysis” (p. 163) his four decades of living as a wealthy loafer: his trouble-making, his provocations, drinking and peculiar relationship to his wife. Being of pathologically jealous “nature,” he suspects her of one (one-hour) act of unfaithfulness, allegedly committed 13 years before, when he himself had suggested in a drunken state in Paris bringing a prostitute into their hotel, to “enjoy” two women at the same time. His wife, less drunk, objected and waited for him in company of a friend. As a result, the husband took a vow of sexual abstinence which he kept for 13 years—with one instance excepted—leading to the conception of the son. That conception, too, was performed under peculiar circumstances: He first offered his wife to a house guest.

This book is psychologically confused, naïve, out of focus. The “self-analysis” of the hero leads only to flash-backs—with complete lack of understanding. One could object that the hero must be naïve about his real motivations. Quite true; but the real writer must—unwittingly—intimate the real connections; that is exactly the distinguishing mark between a creative writer and a man who uses a typewriter. Nothing of that kind can be found in Wakeman’s book; there is no inkling as to why the hero commits a long series of “nautical crimes” (p. 51), for instance “forgetting” the life preservers. The explanation offered by the author is naïve (guilt because of conscious aggression).

To complicate matters, the book is psychologically pretentious, even carries a “picture of the unconscious,” taken from Jung’s collection, on the jacket. That pompous and “know-all” attitude blocks even the author’s mild efforts to understand the masochistic substructure of the hero. Everything is wrongly explained, every psychiatric implication worthless. The publisher, by the way, plays an unwitting joke on the author: He asserts that the book proves “Wakeman’s ability to grow with experience.” The best which can be said about the “wastrel’s” soul-searching on the raft, is that it is unproductive. The author’s truest words (put into the mouth of the hero) are those on page 163: “What was their [the wastrel’s and his wife’s] trouble? *I don’t know.*” That psychologic naïveté is the theme song of the whole book which constitutes a flagrant example of the misuse of psychiatry for sensationalism.

**The Freudian Psychology and Veblen’s Social Theory.** By LOUIS SCHNEIDER. 270 pages. Cloth. King’s Crown Press. New York. 1948. Price \$3.25.

There are books written on the principle of: What is the connection between a jazz band, the moon, and the Empire State Building? The answer is simple enough: A jazz band plays in moonlight under the Empire State

Building . . . The present volume is of that type: It connects Freud and Veblen. The irony and lack of discernment rests on the fact that the author himself acknowledges the senselessness of the repeatedly attempted comparison between Marx and Freud, and still goes on naïvely with his pet comparison.

Veblen was a sociologist who claimed the importance of the "instinct of workmanship"; he claimed also that all men have a "quasi-aesthetic sense of economic or industrial merit, and to this sense of economic merit futility and inefficiency are distasteful." His main opinions of our culture are explained in his book *The Theory of the Leisure Class*.

Instead of explaining the superficialities imbedded in these theories, Schneider (assistant professor of sociology, Colgate University), takes his Veblen for his Bible (though he criticizes him sometimes, indicating that Veblen and Freud would have done better in consulting the author first), and goes on building his sociologic universe. Veblen gets passing marks; Freud, however, would not have graduated in Schneider's class. The professor's sympathies are all with neo-Freudians; that means decisive parts of basic analytic theories have to be eliminated, to suit Schneider. Sometimes, he even out-neo-Freudians the neo-Freudians.

The purpose of the whole procedure? A "new angle" is discovered which turns out to be but the continuation of outworn misunderstandings. The book contains many misunderstandings of psychoanalysis (naïve ideas on the super-ego, ignorance of pre-Oedipal concepts, fantastic claims of Freud's "anarchism," and similar notions), and has long chapters on rationality and the political situation in Germany.

For psychiatrists the book is without interest.

**Father Land.** By BERTRAM SCHAFFNER, M. D. 203 pages. Cloth. Columbia University Press. New York. 1948. Price \$3.25.

Nearly four years after V-E Day the settlement of the "German Question" is yet a distant goal to be achieved. It occurs to this reviewer that our policy-making experts might well profit from reading Dr. Schaffner's book and thus gain insight into the basic cultural and psychological structure of the people whom they expect to function under a democratic system. The author obtained his extensive knowledge of German mentality through early periods of work and study in Germany, and as psychiatrist at the screening center of the Information Control Division in the U. S. zone of Germany during 1946. At this center candidates for newspaper and publishing positions were submitted to a three-day screening procedure, including an analysis of their past political activities; measurement of intelligence, the Rorschach personality test, an incomplete sentence test, and observation and psychiatric interview. From his experiences and an analysis of the data, Dr. Schaffner found substantiation for the psycho-

analytic assumption that parental attitudes, derived from tradition, determine the cultural character. In his discussion he primarily traces the origin of German authoritarianism, reaching the conclusion that "the authoritarianism found in German political life stems directly from the autocratic position of the father in the German family."

The main part of the book deals with a comprehensive examination of German family life, stressing the complete subordination of mother and children to the authority of the "omnipotent, omniscient, and omnipresent" father. The author attributes the need for authority, lack of independence and rigidity found in the German adult to the essentially passive and obedient attitude of the young child toward the father, and explains Hitler's acceptance by his functioning in the role of the traditional German father. As evidence for his conclusions he offers frequent examples of attitudes expressed in the sentence completion test.

The second part of the book is made up of appendices and includes a detailed description of the work at the screening center, the psychological tests used, and five representative case histories. A preface by Dr. Margaret Mead and foreword by Dr. David M. Levy introduce the work.

The material and Dr. Schaffner's skillful analysis demonstrate the eventual futility of efforts to reconstruct Germany by "de-Nazification" and the introduction of alien attitudes. While realizing the exceeding difficulty of altering a traditional culture, the author stresses the importance of substituting for the present program a long-range program of re-education, which must concentrate on modification of the culturally determined character through changes in interpersonal relations and family life. Dr. Schaffner's recommendations are well-founded. The work is of great interest not only in its attempts to analyze a nation's psychology—done in clear-cut and comprehensive terms—but also in demonstrating the fruitful possibility of applying psychiatric and anthropological theories to the formulation of political structures.

**Life with Family.** By JEAN SCHICK GROSSMAN. 231 pages. Cloth. Appleton-Century-Crofts, Inc. New York. 1948. Price \$3.00.

Mrs. Grossman, director of parent education of the Play Schools Association, aims to assist the parent toward better familial relations. She enlarges on common situations which occur in the home and advises how to handle them. She is in accord with existing theories that children cannot be forced through stages of development; she feels they should find their own direction and rate of growth. She discusses many matters vital to the welfare of family and the child, in particular, handling money, getting along with others, having fun in the home, and the problems of the working mother. Mrs. Grossman's points are illustrated by amusing incidents and anecdotes from the experiences of herself and her friends.

**The Doctor and the Difficult Child.** By WILLIAM MOODIE, M. D., F. R. C. P., D. U. M. 231 pages. Cloth. The Commonwealth Fund. New York. 1947. Price \$2.00.

This book by an English psychiatrist, medical director of the London Child Guidance Clinic, is written in simple, unaffected language and, in spite of its brevity, well covers the field of guidance of the problem child. The author points out that the child guidance psychiatrist must realize that the parent, who employs unorthodox or violent methods, must have some personal reason for doing so, therefore needs more help than the child. This is a well-accepted axiom in this country, where an effort is made to orient parents in relation to their own problems as well as to the actual treatment of the child.

In his discussion of treatment, Dr. Moodie shows how approaches to the child's problems can be made from the interpretation of his play, drawings, fantasies, etc.; and he offers helpful suggestions in winning the confidence of the child and finally diagnosing his difficulties. There is an excellent discussion of the problems encountered in the average child guidance clinic. There is also a chapter on recommendations for the proper constitution of a child guidance clinic. In general, this is an interesting little volume which the reviewer heartily recommends to workers in this field.

**Victors' Justice.** By MONTGOMERY BELGION. 187 pages. Cloth. Henry Regnery Company. Hinsdale, Ill. 1949. Price \$2.75.

For the benefit of skeptics, Mr. Belgion is a British author whose book indicates that he served with the British army.

His thesis concerning the postwar trials of the Germans is that "it is solely by the exercise of lawless force that victors in a war can seize individuals among the vanquished . . . and . . . proceed to try and punish them. . . . It is merely to carry on war after the fighting is ended. It is merely to carry on a coward's war." Mr. Belgion charges that the Nuremberg and other tribunals were set up without right or authority, that the planning and waging of aggressive war was a charge impossible to substantiate, and that, concerning the charges of war crimes and crimes against humanity, a proper defense is, "You too." Mr. Belgion indicates that the Russians were soaked in blood, that the Americans and French behaved disgracefully and that the British were not much better. Concerning American fair play, he notes that: "In the United States cricket is played only at Philadelphia and on Staten Island." Mr. Belgion notes—with what to this reviewer appears to be relish—that "We know it to have been contended that Roosevelt wanted to involve the United States in the war and schemed to provoke Japan. He notes similarly an alleged order, concerning which he seems surprised "that there has been no avowal or denial," to British and American troops "to take no prisoners when

they landed in Normandy." Concerning the persecution of Jews, the author observes that those found guilty at Nuremberg were convicted of the murder of foreign, not of German, Jews, most of whom "who could afford it were up to the outbreak of war allowed to emigrate." Against this "injustice" in the killing of Jews, Mr. Belgion sets forth "injustice" in the Allied program of de-nazification which he holds illegal even though carried out in part by Germans under Allied rule.

This study should interest jurists, psychologists and, in particular, psychiatrists. Perhaps copies of it should be distributed behind the Iron Curtain as an example of Anglo-American freedom of the press. And perhaps all of us should ponder seriously the author's contention that if murder, rape and robbery are committed during a war the victors have no right to punish the conquered offenders.

**The Myth of the Magus.** By E. M. BUTLER. 282 pages with index. Cloth. The Macmillan Company. New York. 1948. Price \$3.75.

This book is a series of brief sketches of the noteworthy characters, imaginary and real, who have been outstanding in the history of magic throughout the centuries. The Magi were priests of ancient Persia. The practice of magic, like the later practice of witchcraft, involved the worship of pagan gods.

There is a characteristic pattern running through the life histories of magicians. For the most part there is a pact with a demon, brief dominion over air, land and sea, and death as a reward. Magic could be invoked in the service of good as well as of evil. Its practitioners unquestionably included men and women who mixed supernormal and paranormal abilities with the trickery which has been inherited by the modern stage magician as the last vestige of age-old rites. Solomon and Virgil were reputed great magicians.

Butler speculates that both Christ and Joan of Arc may have been magicians, that is white magicians, persons initiated in the mysteries of an ancient practice for the good of mankind. If this is so, there is unusual drama in the parallel fates—at almost the same time and place—of the Maid of Orleans and of Gilles de Raix, one of the most monstrous of the black magicians concerning whom details can be verified. Perhaps of greatest interest as a character is Faust, disreputable vagabond and mountebank. The scanty records show, for example, his expulsion from an unimportant German community as a noted sodomist. A credulous Swiss preacher, Marlowe, and Goethe combined to make him the great tragic figure of his kind, the man who sold his soul to the Devil and reaped the consequences. Marlowe's story of Faust is the paradigm of that of all black magicians; it is of vital significance in the study of dynamic psychology of the individual and of mankind.

**Everyday Psychiatry.** By JOHN D. CAMPBELL, M. D. 380 pages. Cloth. J. B. Lippincott Co. Philadelphia. 1949. Price \$6.00.

Although this book is one of several written in simple language and basically for the general practitioner of medicine and for the layman, it would also make a good text. It has been popular; and this is the second edition, differing from the first—which contained much material pertaining to military problems—by emphasizing psychiatric problems in civilian practice. There is a new chapter on "Involutional Syndromes and Involutional Melancholia," a discussion of electric shock therapy, and additional discussion of the manic-depressive psychosis. The chapters on the psychoneuroses and on chronic alcoholism have been rewritten. The author, now on the faculty of Emory University Medical School, emphasizes that his intention has been to "deal with the milder mental aberrations, that great number of psychosomatic problems which come daily to the attention of the general physician and specialist."

This book is good reading and well presented. It contains a bibliography after each chapter and a detailed index at the end of the book.

**American Children Through Their Books—1700-1835.** By MONICA KIEFER. Foreword by Dorothy Canfield Fisher. 248 pages, including bibliography and index, 11 illustrations. Cloth. University of Pennsylvania Press. Philadelphia. 1948. Price \$3.50.

This is a book of special interest to social workers, teachers, and psychologists, in which the author traces the changing status of the child in America from the colonial period through the early nineteenth century. Development of the various phases of child life is presented mainly through illustrative material chosen from the juvenile literature of the times. With humor and irony the author paints a verbal picture of the colonial child, emphasizing his insignificant status in the family and in the community—his life dominated by theological concepts.

With the gradual disappearance of Puritanical dogmas, the child achieved a new status and became a distinct personality. Fear of sinful transgressions was replaced by a spirit of toleration and a desire for happiness. Rules of good conduct and moral stories tended to form a less stringent code of ethics, but one which encouraged a child to develop habits of honesty and industry. The book confirms what psychologists today are stressing: (1) the importance of early childhood experiences in influencing and molding character, and (2) the recognition of children as determinants of a future society. And whether that future society will be good or bad largely rests with us—their protectors, teachers, and guides.

**The Issue of Compulsory Health Insurance.** By GEORGE W. BACHMAN and LEWIS MERIAM. 271 pages with index. Cloth. The Brookings Institution. Washington, D. C. 1948. Price \$6.00.

**Voluntary Medical Care Insurance in the United States.** By FRANZ GOLDMANN. 228 pages with index. Cloth. Columbia University Press. New York. 1948. Price \$3.00.

This is a Brookings Institution survey, prepared at the request of Senator H. Alexander Smith, chairman of the subcommittee on health of the Senate Committee on Labor and Public Welfare.

Doctors Bachman and Meriam find American health in general to be better than has been represented by the proponents of compulsory federal health insurance. They believe that under voluntary medical care the United States has made greater progress in the application of medical and sanitary science than any other country. They believe this trend will continue, and do not favor compulsory health insurance on a national scale at this time. Since this appears to be the view of the majority of the medical profession, practitioners everywhere will find this volume a basic work on the subject.

Dr. Goldmann makes a survey and analysis of voluntary medical care insurance as it exists at present in the United States. He discusses its possibilities and its limitations. Among the dangers to the future of voluntary insurance plans he sees not only the possibility of compulsory medical care insurance but the possible subsidizing of voluntary activities to the point where they become less voluntary than governmental. He warns against making poor medical care "more easily available." He sees the future of voluntary care in the combination of group pre-payment and group practice, and in the inclusion of comprehensive professional services and hospitalization in a single program.

**Medical Addenda.** Related Essays on Medicine and the Changing Order. 156 and xviii pages, with foreword, and preface by Franklin B. Kirkbride. Cloth. Commonwealth Fund. New York. 1947. Price \$1.75.

These essays constitute a primer on the place of medicine in the social system as it is developing, and as it may be projected in the foreseeable future. In general, it seems that the pursuit of medicine as an individualistic occupation is a thing of the past, and that the sick person of the future must face a professional "team," or go without professional care. To shed a tear for the old order is almost as bad as to admit to racial bias or a dislike of unions, so—let us hope that the team will be generous in its treatment of psychiatrists and other physicians. As far as this particular selection of monographs is concerned, it may be recommended safely for elderly general practitioners who wish to recapture the illusion of living dangerously after retirement. Its connection with medical problems is academic rather than actual, today.

**The Relation of Diseases in the Lower Animals to Human Welfare.**

By W. A. HAGAN, et al. *Annals of the New York Academy of Sciences*. Vol. XLVIII, Art. 6, pp. 351-576. 1947.

The importance of the exchange of knowledge and progress between human and veterinary medicine cannot be overemphasized. The bonds between these two disciplines are, however, generally very loose and superficial. The reviewer of the conference on which this book is based had the opportunity to benefit from, and to experience, teamwork with veterinary surgeons in experimental pathology, chemotherapy and epidemiology. Even in clinical work, training in veterinary medicine proved to widen the spectrum of knowledge and to strengthen the clinical "fingertip feeling" of physicians for practical medicine. Thus one must welcome the conference on the relation of diseases in animals to human welfare. (W. A. Hagan.)

Rabies (H. N. Johnson), equine encephalomyelitis (R. A. Kelser), psittacosis, ornithosis and related viruses (H. R. Cox), brucellosis (I. Forest Huddleson), plague (K. F. Meyer), anthrax (C. D. Stein), erysipeloid (J. V. Klauder), tuberculosis (W. H. Feldman), and—most important—animal parasites transmissible to man (W. H. Wright) are discussed in a competent and interesting manner. One can with justification generalize H. W. Stunkard's final remark on the presented material: "... it will undoubtedly afford a surprise to most readers, and demonstrates the importance of the diseases of lower animals to human welfare."

**Psychological Atlas.** By DAVID KATZ. 295 pages with 400 illustrations. Cloth. Philosophical Library. New York. 1948. Price \$5.00.

This book is a compilation of pictures to illustrate concepts in general psychology, characterology and topology, developmental psychology, physical handicaps, abnormal psychology and psychiatry, occult phenomena, applied psychology and animal psychology. For the student of psychology the book has little to offer except, perhaps, a review, in picture form, of material previously covered in graduate and undergraduate courses. The book is divided into two parts, one containing explanations of the illustrations, and the other part the "pictures." It would have been much easier for the reader if the explanations had followed the illustrations, thus eliminating constant flipping of pages from one part to the other. Much of the material present is too well known to belong in a book of this nature, particularly, the four Rorschach cards, drawings of children, Szondi pictures, etc. The last chapter consists of seven pages of photographs of "eminent psychologists."

**Selected Writings of Gertrude Stein.** Carl Van Vechten, editor. 622 pages. Cloth. Random House. New York. 1946. Price \$3.50.

This collection from Gertrude Stein's writings was made shortly before her death and with her approval. It includes material from all periods of her writing life and contains some of her most controversial works.

Gertrude Stein has always been of particular interest to the psychologist. It may be poor literary criticism, but possibly not too far from the mark psychologically, to think of genius having at its disposal the rich irrationality of schizophrenia, the valuing of words for words' sake, or conversely, the expression of emotion without too much regard for the mental content of words. Of course, there is no more of the irrational or the psychopathic in Gertrude Stein than in the majority of us. She simply had extraordinary access to its depths and extraordinary facility in expressing it. And, of course, Miss Stein's mentality was of an order not to be questioned. This reviewer has seen nothing clearer or more brilliant written about the great retreat of the Germans than "A Picture of Occupied France" and "The Coming of the Americans" as she has presented them in this book.

**World Communism Today.** By MARTIN EBON. 536 pages with index. Cloth. Whittlesey House. New York. 1948. Price \$4.50.

This is a survey and guidebook to Communism as it exists today and as it is projected for the future. It appears to be factual and is based, as the extensive bibliography indicates, on an enormous amount of research. It gives data on the strength and the organization of Communist parties throughout the world. As Communism's weapons today are chiefly psychological, this book is valuable reference material for all who are engaged in fighting, or may be called upon to fight, this most powerful of modern irrationalities.

**The Psychology of Imagination.** By JEAN-PAUL SARTRE. 285 pages. Cloth. Philosophical Library. New York. 1948. Price \$3.75.

Sartre states: "This book aims to describe the great function of the consciousness to create a world of unrealities, or 'imagination' and its noetic correlative, the imaginary." The book is divided into four parts consisting of "the Uncertain," "The Probable," "The Role of the Image in Mental Life" and "The Imaginary Life." This is an excellent philosophical discussion of imagination in which the author concludes that "imagination is not an empirical and superadded power of unconsciousness, it is the whole of consciousness as it realizes its freedom; every concrete and real situation of consciousness in this world is big with imagination in as much as it always presents itself as a withdrawing from the real." This book is excellent and well written. It should be of interest to all.

**Cybernetics or Control and Communication in the Animal and the Machine.** By NORBERT WIENER. 194 pages. Cloth. The Technology Press. John Wiley & Sons, Inc. New York. Third Printing, January 1949. Price \$3.00.

Wiener's book—not yet a year after it came off the press—already required a third printing! That speaks for itself. Cybernetics (formed by the author from the Greek word for steersman) is the name of a new science which aims to find the fundamental laws of control and of communication theory. The methods of Cybernetics are those of theoretical physics and one of its main aims is to find the common denominator of the functions of automatic computing machines and of the animal nervous system.\*

The "feed-back mechanism," familiar to control engineers, was one important factor which incited Wiener and his co-workers to their studies. Consequently neurophysiologic aspects of conduction and transmission had to be considered, and were studied, from mechanical and mathematical viewpoints; the tools for study were given by statistical mechanics; the theoretical base was found by applying the doctrine of entropy (which could be defined as the theory of the "ideal disorganization").

In team-work with distinguished co-workers Wiener succeeded in conceiving the new science of cybernetics, the epistemologic base of the application of the control and communication theory for the study of "traffic problems" within physiologic chain reactions of living organisms, especially of neurophysiologic phenomena. Though no branch of biologic science is outside the scope of cybernetics, it appears to the medical reviewer at present as if neurophysiology, psychology and psychopathology will gain the most—not only new aspects and understanding, but a field of needed experimental research.

It is not possible to give an overall and fair review of a book which contains the basic facts of a new science which—furthermore—might become the key for a new orientation in the conceptions of physiology and pathology. Especially interesting is the chapter on cybernetics and psychopathology. The daily diagnostic problem of distinction between functional and organic disorders gains a great deal of light by applying cybernetic methods. It is fascinating to follow the author's demonstration of the analogy of the computing machine to the adult brain. We gain a workable theory of what occurs to the communication system in the psychotic brain, and how, e. g., prefrontal lobotomy acts on it. Here, too, is some understanding of the similarities and differences in action of lobotomy and shock therapy and of the point where psychotherapy must set in. The phenomena of handedness and of hemispheric dominance, looked at as a problem

\*See *Teleological Mechanisms*, by L. K. Frank, N. Wiener and others. *Am. N. Y. Ac. Sc.*, 50:4, October 1948; and *Rhythmic Behavior of the Nervous System*, by Hudson Hoagland. *Science*, 109:2825, February 18, 1949.

of "interhemispheric traffic," gain, by Wiener's forceful and convincing demonstration, a new and interesting explanation.

Wiener's conceptions and methods will bear fruit in all fields of active research dealing with problems of technical or physiologic communication. Cybernetics has conquered already an undisputed place as a category under the sciences destined to unveil dark sides of life. The book is written in a fascinating style, keeping the student of the new science in tension and expectation, in spite of the difficult problematic nature of the matter.

**Aureomycin—A New Antibiotic.** By B. M. DUGGAR, et al. Annals of the New York Academy of Sciences. Vol. 51, Art. 2. Pages 175-342, including colored figures and tables and bibliography. Published by the Academy. New York. November 30, 1948. Price \$2.50.

There are no better sources of information concerning progress in therapy than the annals of the New York Academy of Sciences. A model of critical report on original research is the compiled series of papers on aureomycin. Nearly 100 antibiotics are at present under investigation, limited to seven of them for practical study with more or less established therapeutical value (penicillin, streptomycin, fumigacin and streptothricin of fungal origin, gramicidin, thyrothricin and bacitracin of bacterial origin). Each of them has its *therapeutic limitation* and its *specific indication*.

Aureomycin A-377, belonging to the fungal-originated group, is the latest antibiotic under extensive pharmacologic and therapeutic investigation. Its unusual theoretical significance is its wide antibiotic range reaching from gram-positive and gram-negative bacteria (where it seems inferior to penicillin and streptomycin) to *rickettsial* and *virus infection* where it exhibits superior therapeutic activities. Outstanding is the observation that aureomycin penetrates the hemato-encephalic barrier in appreciable therapeutic concentration. It is interesting for the chemotherapist that its activity in *in vitro* experiments is absent or limited, depending on the milieu, and that resistance does not readily appear either *in vitro* or *in vivo*.

It appears from preliminary clinical investigations that aureomycin exerts a dramatic effect on Rocky Mountain spotted fever, lymphogranuloma venereum and Q-fever and has proved to be very effective in the treatment of brucellosis, of chronic urinary infections due to the coliaerogenes group and of skin infections due to hemolytic staphylococcus aureus in new-born infants. Besides, it seems to have an unusually wide spectrum of activity in ocular infections. It is significant that the oral application of aureomycin seems to be superior to the parenteral route, a property most interesting from a chemotherapeutic viewpoint and most important for its practical therapeutic use. More interesting facts on the new antibiotic can be expected after pooling of extended clinical observations.

**Teleological Mechanisms.** By L. K. FRANK, et al. 92 pages, with figures, references and bibliography. Paper. Annals of the New York Academy of Sciences. Vol. 50, Art. 4, pp. 187-278. 1948. Price \$1.75.

This volume deals with an important fundamental problem, attempting to give the epistemological base for the shift of the present scientific approach to a more comprehensive method of dealing with the organized structure and functional activities of living organisms. The psychosomatic concept in medicine may find in this theory an elementary foundation. "The concept of teleological mechanisms . . . may be viewed as an attempt to provide more fruitful conceptions and more effective methodologies for studying self-regulating processes in self-orientating systems and organisms, and self-directing personalities" (L. K. Frank).

Norbert Wiener presents in his study on "time, communications, and the nervous system" experimental data to give convincing evidence of the validity of the teleological mechanism. D. McK. Rioch emphasizes "there are many neurophysio-phenomena to which this method may be immediately applied." G. Evelyn Hutchinson, following the same line in her study on "circular causal systems in ecology," characterizes her mode of approach as "bio-geochemical" and "biodemographic." Those concerned with population policy and vital statistics will have to consider this work thoughtfully. W. K. Livingston, reporting on the "vicious circle in causalgia," deals more with neurophysiological than with psychosomatic concepts. Wiener's work and conceptions are stimulating, and no scientist concerned with the fundamentals of the life of the individual and of society should bypass them.

**Technique of Treatment for the Cerebral Palsy Child.** By PAULA F. EGEL. 195 pages. Cloth. The C. V. Mosby Co. St. Louis. 1948. Price \$3.50.

Miss Egel is now cerebral palsy director, Children's Hospital, Buffalo, N. Y. She has been working for a long time with spastic children, and her experience has been tremendous. She is, therefore, well qualified to write about the treatment of cerebral palsy and to present a manual for teaching purposes, which also can be used by the nurse and by the doctor.

The book contains chapters on cerebral palsy classifications, personalities of the patients, diagnostic tests, massage, active and passive motion, active assisted and resisted motion, conditioned and automatic motion, relaxation, balance, skills and advice to trainers. There are also several pages devoted to a listing of the apparatus and equipment needed. Finally, there is the appendix, "Organization of a Cerebral Palsy Department in a Children's Hospital," written by Moir P. Tanner, superintendent, Children's Hospital, Buffalo.

**Chronic Disease and Psychological Invalidism.** A Psychosomatic Study. By JURGEN RUESCH, M. D., and collaborators. 191 pages with foreword, bibliography and appendices. Paper. Psychosomatic Medicine Monographs. Published with the sponsorship of The American Society for Research in Psychosomatic Problems. New York. 1946. Price \$3.00.

The relevance of combined medical, psychiatric, and social data in the understanding of disease has been long established, especially in the area of chronic illness, but the practical approach to the use of the findings of these methods of investigation has been treated vaguely, if at all. This book, although relatively short for its subject, discusses in a more definite fashion the usual psychosomatic problems, the cultural factors, and the psychotherapeutic approach to these conditions, including selection and prognosis of treatment cases. The chapters on "Psychosomatic Relations," "Situational Conflicts," "Character Problems," and "Social Factors" are especially useful, because of the way they introduce and summarize many psychiatric concepts in disease. This presentation is in unusually concrete fashion, making it possible to visualize and formulate the specific social and personality problems of many patients, many of whom, of course, are found to seek "treatment" rather than "cure."

The authors discuss "short psychotherapy" more clearly than do some books on the subject, a clarity which may have been induced and aided by limitations of space. They found that, in some cases, it seemed sufficient "to shift the patient's attention from symptoms to the personality problem, without discussing the latter in detail" (p. 150), implying that the patient can do a great deal to solve his own problem once he is made aware of what it is. However, elaborations of technique are discussed, including the gathering of material, the timing and content of interpretations, the awareness of fundamental conflicts, and the transference problem. Stress is laid on current, conscious needs, with use of dreams and autobiographical material as apparently secondary, or at any rate, coming later in the treatment. Group psychotherapy was also found to be useful within certain specified limits. It was tried with these "chronic disease" patients, following the observation that they often discussed various problems among themselves. Orthodox psychoanalysis is dismissed as too expensive, too time-consuming, and not applicable to all patients under any circumstances. The authors contend that analysts have been more concerned to select patients suitable for analysis than to modify analysis for the patient.

Inasmuch as this book is a scientific monograph, it contains its share of tables, charts, and descriptions of the methods of investigation. In all probability, most medical readers will find the rest of the book so valuable that they will suffer this distraction without complaint. The psychologists and

sociologists, inured to such practices, may even enjoy the presentation the more because of the authoritative tone which these devices impart to the study.

**Nietzsche, Krankheit und Wirkung.** (Nietzsche, Illness and Effect.)

By Dr. W. LANGE-EICHBAUM. 100 pages. Paper. Verlag Anton Lettenbauer. Hamburg. 1947. Price not stated.

This pamphlet-like booklet is "dedicated to humanity" by the author. Nietzsche's anamnesis, especially his illness as related to the genesis of his literary works, is reported; and the influence his writings exerted on the philosophies of dictators and on world history and world tragedy is discussed.

The pathological grandiosity of the paretic Nietzsche has influenced world history during the last decades. Mussolini as well as Hitler translated into actuality the fantasies of a sick mind. To them the will to power without conscience, the concept of the superman, immunity from guilt and the aim-justifying-the-means were true gospel. The expansive ideologies and poetic fantasies were not conceived as a political platform by Nietzsche. They probably were never meant to become activated in reality.

The progressively deteriorating process of his illness may be correlated with the more and more fantastic omnipotence of a mind in regression.

Nietzsche was born in 1844 and died in 1900. His syphilitic infection was contracted in 1865. Prodromal symptoms of his mental illness were noted prior to 1888. But during that year his central nervous system lues became manifest. The works which brought him infamous fame were produced during the time when he was suffering from general paresis.

The following list of works may correlate illness and its effects: *The Birth of Tragedy*, 1871; *Untimely Meditations*, 1873-1876; *Dawn*, 1881; *Happy Science*, 1881-1886; *Zarathustra*, 1885; *Beyond Good and Evil*, 1886; *Genealogy of Morals*, 1887; *The Wagner Case*, 1888; *The Twilight of the Gods*, 1888; *Nietzsche versus Wagner*, 1888; *Ecce Homo*, 1888; *The Will to Power*, 1887.

The epilogue of *Krankheit und Wirkung* stresses the tragedy of World War II as a "war of insanity." The author feels that Nietzsche originally wanted to develop humanity to lofty heights. We get glimpses of his ideals in *Zarathustra*. Nietzsche himself cherished *Zarathustra* more than any other writing of his. The last paragraph of Dr. Lange-Eichbaum's "epilogue" notes that Nietzsche is one of the most grandiose phenomena and consequences of the problems of "genius and insanity." He thinks that here is a challenge for further studies about these important and interesting problems.

*Krankheit und Wirkung* is an interesting and enlightening pamphlet. It is a valuable contribution to the understanding of Nietzsche, the man, the author and poet—and his influence on world history.

**Beyond the Forest.** By STUART ENGSTRAND. 303 pages. Cloth. Creative Age Press. New York. 1948. Price \$3.00.

Engstrand's new book is boring, banal, pretentious, and psychologically confused. One could close the review with this dictum. If this reviewer takes the trouble to enumerating *some* of the psychological misconceptions, he does it only because the book can be used as example of what is done with psychiatry in so-called literature.

The author describes a "Wisconsin Bovary," dissatisfied in her marriage with a country doctor. She (Rosa) treats him with coldness, contempt, and reproaches; in her "queenliness," she dreams of a better life. The husband, a Milquetoast, takes all that; he wants but "happiness." Rosa, the heroine, tries to "hook" a wealthy man, gets pregnant by the husband at exactly that inopportune time, tries to achieve a miscarriage by a steep fall in the woods, reaches her aim but also acquires a tetanus infection, and—dies.

That banal plot is dressed up as a "battle of the sexes" (quoted from the jacket), and, even worse, as a psychological study of frigidity. As such it is a silly flop. Rosa has no life of her own: She breathes the dusty air of libraries inhaled by the author while reading and misunderstanding psychiatry (and mostly outdated) textbooks. Rosa is also a composite and artificial picture: a piece of one case history here, another facet from another case history there, ineptly combined, adding up to not more than pretentious contradictions. The result is confusion: If Rosa is a case of hysterical neurosis, then a murder of a competitive girl (killing the girl's father by chance) does not tally. Hysteria and eriminosis are different entities. If, on the other hand, Rosa is a "castrating female," the constantly aduced element of pride does not mean anything as genetic motivation, nor is her friendly, detached, at best half-tender relationship to her own father understandable. Rosa's mother is conveniently not mentioned (she died early); how a psychological novel can do without the role of the mother in the child's development is not clear.

The high point of psychological absurdities is reached in Moose, the husband's friend. Moose acts as philosopher and psychologist of the would-be drama. First, he himself sacrificed a fine future and abandoned his wife, a senator's daughter, and his two children, because of unsettled inner guilt pertaining to the killing of enemy soldiers in the war. He becomes a hermit and drinker—his alcoholic addiction being naïvely explained on the same basis. Then, he proclaims freedom of will; simultaneously he dwells upon two "slightly" unconscious psychic principles, equally reduced to absurdity. Moose discovers in Rosa a death instinct ("He had often said that she did not like life. Well, then life has not been her goal. Death had been her goal.") To complicate matters, Moose even proclaims a theory for paranoiae schizophrenia: "We can't go around weeping about Hitlers

... because of what happened to them in their infancies ... Maybe they had incest urges with their mothers. ..."

Having checked up all important titles in his psychiatric books, Engstrand reverts to simple psychology: "Infants like you [Rosa] get spanked." Spanking, Oedipus, and death-instinct, nicely wrapped, are then delivered to the naïve public which will take the mixture as an "authoritative" and "interesting study" of character.

Unfortunately, not the slightest inkling of the dynamic factors in the personality is visible in the book even with a magnifying glass. The role of psychic masochism is fully misunderstood. Rosa's husband's masochistic submission is explained as craving for love: "He was never fully weaned, he's spending his life look for a pap, and you're [Rosa] not the breast-feeding type." Obviously, the textbooks the author consulted, do not yet mention what "psychic masochism" means.

Other medical absurdities are: ignorance of the AZ test in pregnancy. A great deal of the plot hinges on Rosa's alleged pregnancy; still nothing is done to clarify the issue. The same applies to not giving an anti-tetanus injection in a wound soiled by earth. The Wisconsin Medical Society should protest.

Engstrand previously wrote a bestseller *The Sling and the Arrow*, misunderstanding—more modestly—only one specific chapter in psychopathology: homosexuality. His appetite increased, and the go-getter attitude in misunderstanding now comprises a series of chapters. Some progress though, is visible: The publisher informed the eager readers of *The Sling and the Arrow* that "Mr. Engstrand found his theme for *The Sling and the Arrow* last year when he was re-reading Stekel's writings on abnormal psychology. That announcement is missing in the present book.

**Current Trends in Clinical Psychology.** By A. W. COMBS, M. L. HUTT, J. G. MILLER, J. L. MORENO and F. C. THORNE. 62 pages. Paper. New York Academy of Sciences. 1948. Price \$1.50.

This is a series of papers on the current trends in clinical psychology by the four authors listed. Thorne writes on "Theoretical Foundations of Directive Psychotherapy." Combs discusses "Some Dynamic Aspects of Non-Directive Therapy; Durkin, "The Theory and Practice of Group Psychotherapy." Psychodrama and group psychotherapy are discussed briefly by Moreno. Hutt writes on "What the Clinical Psychologist Learned from the War." Miller outlines a program for "Future Training in Clinical Psychology."

Miller's program for clinical training is amusing, but not practical. The other papers are rather interesting. However, as a whole this could well have been left unpublished in that it make no new contribution, and much of what is covered is a re-hash of previously discussed material.

## CONTRIBUTORS TO THIS ISSUE

**BEN KARPMAN, M. D.** Ben Karpman was born in Russia in 1886. He was educated in America at Columbia University, the University of North Dakota and the University of Minnesota, where he received his medical degree in 1920. He later did postgraduate work in Europe, chiefly in psychoanalysis. Dr. Karpman is now chief psychotherapist at St. Elizabeths Hospital, Washington, D. C. He is the author of some 40 pieces of published work, including several books, and is editor of *The Journal of Clinical Psychopathology*.

**HERMAN B. SNOW, M. D.** Dr. Snow, born in New York City in 1909, was educated at Syracuse University and is a graduate of Syracuse University College of Medicine from which he received his medical degree in 1933. After a year's general internship, he joined the New York State hospital system at Binghamton State Hospital. He served at Binghamton until 1940 when he entered the army, from which he was discharged in 1946 as a lieutenant-colonel, returning to state service at Binghamton. He became assistant director (clinical) at Utica State Hospital in September 1948 and was named assistant director (administrative) in April 1949. Dr. Snow is married and has two children. His hobby is bowling, of which he is an enthusiast.

**EDWARD STAINBROOK, Ph.D., M. D.** Edward Stainbrook, a graduate of Allegheny College in 1935, served for the next three years as a clinical research psychologist in various state hospitals. He was chief psychologist of Duke University psychological service from 1939 to 1941. Dr. Stainbrook received both his doctor of philosophy and doctor of medicine degrees from Duke in 1945, after which he interned in medicine, neurology and psychiatry at Bellevue Hospital, New York City. He served as assistant resident in psychiatry at the Payne Whitney Clinic and as resident psychiatrist at the New York State Psychiatric Institute; he is at present instructor in psychiatry at Yale University School of Medicine. Dr. Stainbrook is the author of various articles on experimentally-induced convulsions, electric shock, psychiatric nursing, and the history of psychiatry.

**LIBERO ARCIERI.** Libero Arcieri is a school psychologist with the bureau of child guidance, New York City. Born in New York, he was graduated from the College of the City of New York in 1940. After military service from 1942 to 1945, he attended the State University of Iowa, from which he received his master's degree in clinical psychology in 1947. He was research assistant at Norwich (Conn.) State Hospital and was junior psychologist with the New York State Department of Mental Hygiene's bureau of child guidance before taking his present post in New York City.

NANDOR FODOR, LL.D. Dr. Fodor, a native of Hungary, is an analyst in New York City. He was formerly a research worker in psychical phenomena and later an analyst in Europe, a change of profession to which he was led through investigation of a Poltergeist which he interpreted (and exposed) by psychoanalysis. Dr. Fodor's present paper is part of a book, *The Search for the Beloved*, which will be published in the fall. He is the author of numerous reports on psychical and psychopathological subjects, including previous papers in *THE PSYCHIATRIC QUARTERLY* on the same theme as the present one.

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GEORGE H. STEVENSON, M. D. Dr. Stevenson is superintendent of Ontario Hospital, London, Ontario, and professor of psychiatry at the University of Western Ontario. A graduate of the University of Toronto, practically his entire professional career has been spent in the mental hospital service of the Province of Ontario. He was president of the American Psychiatric Association 1940-1941, having previously been a member of the council and chairman of its committee on nursing. He is at present chairman of the committee on international relationships. Dr. Stevenson is a fellow of the Royal Society of Canada. He has made many contributions to psychiatric literature, and is co-author (with Leola E. Neal, Ph.D.) of *Personality and Its Deviations*. He is at present a representative of the American Psychiatric Association on the board of directors of the American Board of Psychiatry and Neurology.

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STEPHEN MAJOR, M. D. Stephen Major was born in Hungary in 1904 and was graduated in medicine at Milan, Italy, in 1931. After a three-year internship, he practised internal medicine in Milan until June 1940. He served as assistant resident at Long Island Hospital in Boston in 1942 and 1943. He joined the staff of Binghamton State Hospital in 1943 and at present is a supervising psychiatrist there. Dr. Major is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. Previous articles by him have appeared in the *New York State Journal of Medicine* and in *THE PSYCHIATRIC QUARTERLY*.

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REGINALD J. YOUNG, M. D. Dr. Young, born in 1910, received his pre-medical education at Huron College, Huron, S. D., and his medical education at the University of Nebraska, College of Medicine. He has been on the staff of Binghamton State Hospital since 1935. Dr. Young has taken postgraduate courses in the Rorschach technique at Chicago and New York, and a paper by him on differential diagnosis by the Rorschach test was recently published in the *American Journal of Psychiatry*. Dr. Young is a diplomate of the American Board of Psychiatry and Neurology. He is married and has three children.

EDGAR A. P. KELLERMAN, M. D. Dr. Kellerman is a graduate in arts of Columbia University in 1936 and received his M. D. degree from the New York University College of Medicine in 1939. After two years of internship, he served in the navy from 1941 to 1945, attaining the rank of commander. He later was resident in psychiatry at Kings County Hospital and a resident psychiatrist at Brooklyn State Hospital. He has been an affiliate of the New York Psychoanalytic Institute since 1946. He is on the staffs of Brooklyn Hospital and Kings County Hospital, is instructor in psychiatry at the Long Island College of Medicine, and is on the teaching staff of the Postgraduate Center for Psychotherapy, New York City. He has been in private practice in New York City since 1948.

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MORRIS D. RIEMER, M. D. Dr. Riemer was born in New York City in 1904. He attended Columbia College and received his M. D. degree from Long Island College Hospital in 1927. After an internship at Broad St. Hospital in New York City he joined the staff of Brooklyn State Hospital, leaving that institution as a senior assistant physician to enter private practice in 1943. He received his psychoanalytic training at the New York Psychoanalytic Institute. He has been on the psychiatric staffs of the Brooklyn Jewish Hospital and Greenpoint Hospital. From 1937 to 1940 he was associate director of the Brooklyn child guidance clinic. He is a member of the American Psychiatric Association; The New York Society for Clinical Psychiatry and the Brooklyn Psychiatric Society. He has written various scientific psychiatric papers, a number of which have appeared in this journal. He is married and has two daughters.

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ALBERT ELLIS, Ph.D. A native of Pittsburgh, Albert Ellis is a graduate of the College of the City of New York and holds a master's degree and his doctorate in philosophy from Columbia University. He is a consulting psychologist in New York City, specializing in marital counseling. He has been a contributor of numerous articles to scientific publications since 1945.

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DAVID P. AUSUBEL, M. D. Dr. Ausubel received his medical degree (cum laude) from Brandeis in 1943. He had previously specialized in psychology, holds a master's degree in psychology from Columbia, and is at present doing graduate work for a Ph.D. in child development at that university. He has served in the United States Public Health Service in Germany, Nicaragua and this country. He was formerly on the staff of Buffalo State Hospital and is now in the private practice of psychiatry in Brooklyn.

HANS J. KLEINSCHMIDT, M. D. Dr. Kleinschmidt studied medicine at the University of Freiburg, Berlin, Innsbruck and Padua, graduating from the latter with the degree of M. D. in 1938. He was assistant physician in the Ezrath-Nashim Mental Hospital in Jerusalem, from 1942 to 1946. He has been at Hillside Hospital, Bellerose, N. Y., since 1946. He has published a number of papers on shock treatment in *Harefu'a*, *Acta Medica Orientalia*, and THE PSYCHIATRIC QUARTERLY.

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JOSEPH S. A. MILLER, M. D. Joseph S. A. Miller received his medical training at McGill University, Montreal, graduating with the degree of M. D. C. M. in 1928. He obtained his basic psychiatric training at Kings Park State Hospital from 1928 to 1933; he served at Rockland State Hospital from 1933 to 1947, the last five years of that period as clinical director. For the past two years he has been medical director of Hillside Hospital. He received his psychoanalytic training at the New York Psychoanalytic Institute from 1940 to 1945. He is a fellow of the American Psychiatric Association and a member of the New York Psychoanalytic Society, as well as of other national and local psychiatric associations. He is also a diplomate of the American Board of Psychiatry and Neurology. His interests include nosological and therapeutic problems in psychiatry, the postgraduate training of physicians in psychiatry, and the application of psychoanalytic principles to the dynamics and treatment of mental disorders. He is the author of a brief classification of medical and psychiatric literature.

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MARTIN H. ORENS, M. D. Dr. Orens received his medical degree from New York University Medical School in 1940. He was in active military service in the U. S. Army Medical Corps from 1942 to 1945, and was discharged with the rank of captain. He received his basic psychiatric training as a resident at Hillside Hospital from January 1948 to March 1949. He is now in private psychiatric practice in New York City, and is a senior student at the New York Psychoanalytic Institute.

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LESTER COHEN, M. D. Lester Cohen received his medical training at New York University, graduating with the degree of M. D. in 1926. He is a diplomate of the American Board of Internal Medicine, is chief visiting physician and director of the department of medicine at Hillside Hospital, and is also associate attending physician at Coney Island Hospital. Dr. Cohen is interested in psychosomatic medicine, is a member of the American Psychosomatic Society, and has published a number of papers on clinical medicine and cardiology.

## NEWS AND COMMENT

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### HARRY STACK SULLIVAN, M. D., DIES AT 56

Harry Stack Sullivan, M. D., founder and first president of the William Alanson White Psychiatric Foundation and editor of the quarterly journal *Psychiatry*, died in Paris on January 14, 1949. He was on his way home from a meeting of the executive board of the World Federation of Mental Health.

Dr. Sullivan, the author of numerous books and scientific articles, was internationally known for his work in schizophrenia. In 1947, he received the first William Alanson White Memorial Award for his services to psychiatry. Dr. Sullivan was consultant in psychiatry to the Selective Service System during the early part of World War II. He had been in ill health for some time.

The board of trustees of the William Alanson White Psychiatric Foundation has announced that a special issue of *Psychiatry* will be dedicated to Dr. Sullivan's memory and that a Harry Stack Sullivan Memorial Fund will be established.

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### INTERNATIONAL CONGRESS OF PSYCHIATRY CALLED

An International congress of psychiatry, the first ever conducted, will be convened in Paris from October 4 to 12, 1950, it has been announced by an organizing committee formed at the initiative of the interested French scientific societies and following an international preparatory meeting in 1947. The congress was first intended for 1949 but because of "material difficulties," had to be postponed a year. There will be six plenary sessions, devoted to: general psychopathology; clinical psychiatry; psychiatric anatomy-physiology; psychiatric biological therapy; psychotherapy, psychoanalysis, psychosomatic medicine; and social psychiatry. Franz Alexander, M. D., of Chicago will be chairman of the section on psychotherapy, psychoanalysis and psychosomatic medicine, and the general subject for the session of that group will be "The Evolution and Present Trends of Psychoanalysis." A seventh section will deal with the general subject of child psychiatry.

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### DR. KARL BONHOEFFER DIES IN BERLIN

Dr. Karl Bonhoeffer, who was made an honorary member of the American Psychiatric Association in May 1948, the first German scientist so honored since World War II, died in Berlin on December 4, 1948. Dr. Bonhoeffer was professor of psychiatry at the University of Berlin from 1912 to 1938. He lost a son and two sons-in-law when they were killed by the Nazis for their part in the unsuccessful attempt on Hitler's life in 1944

## NEW "DIGEST" FOR PARENTS PUBLISHED

*The Child-Family Digest*, a monthly publication edited by Gayle Aiken and Charlotte Aiken, as a non-profit, educational journal for parents, has brought out its first issue. The magazine is intended to condense or reprint for general reading articles from both popular publications and such scientific journals as *THE PSYCHIATRIC QUARTERLY* and *The Nervous Child*. Dr. James Clark Moloney, co-founder of the Cornelian Corner, and Dr. Ernest Harms, editor of *The Nervous Child*, are among members of the board of advisory editors. The journal, published at 5320 Danneel Street, New Orleans 15, La., is expected, its editors state, to go into a foundation. Introductory subscription rates are \$2.00 for six months.

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## OCCUPATIONAL THERAPISTS TO MEET IN AUGUST

"Dynamic Forces in Occupational Therapy" has been announced as the general theme of the 32d annual convention of the American Occupational Therapy Association in Detroit, August 20-27, 1949. Barbara Jewett, O. T. R., director of occupational therapy at Wayne University, Detroit, and Adaline Truax, O. T. R., of Herman Kiefer Hospital, Detroit, are convention general chairman and program chairman.

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## CHILE SEEKS SCIENTIFIC LITERATURE

An appeal for gift books and medical periodicals is being made by the National Committee for Chile, Room 318, Library of Congress, Washington, D. C. The books are to replace materials recently lost by fire at the library of the medical school of the University of Chile. The newer materials in the library were totally destroyed.

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## L'ENCÉPHALE RESUMES PUBLICATION

*L'Encéphale, Revue de Neurologie, Psychiatrie, et Médecine Psychosomatique* has announced resumption of publication following interruption by the war. The announcement by scientific directors, Professors Jean Lhermitte and Jean Delay recalls that the publication was of international importance before the war, with a large circulation outside France, in particular in Italy, Spain and Latin America.

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## PSYCHODRAMATIC INSTITUTE CONFERENCES

The Psychodramatic Institute of Beacon, N. Y., has announced its seventh, eighth and ninth national conferences for the summer and fall of 1949. An "Independence Workshop" will be conducted on July 2, 3 and 4; a "Labor Workshop" on September 3, 4 and 5; and a "Thanksgiving Workshop" on November 26 and 27.

## POSTGRADUATE PSYCHIATRIC COURSE OFFERED

The University of California Medical School (The Langley Porter Clinic) has announced a 12-week postgraduate course in psychiatry and neurology to be given in San Francisco from August 29 to November 18, 1949. The course will be under the chairmanship of Karl M. Bowman, M. D., professor of psychiatry at the University of California.

